STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155211	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Lebanon, The	1585 Perry Worth Rd Lebanon, IN 46052

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, interview, and record review, the facility failed to ensure grievance forms and/or a grievance process was readily and easily accessible for residents for 43 of 43 residents who resided in the facility. Findings include: No grievance forms and/or posted grievance instructions were observed throughout the survey period during daily observations of the front lobby, outside of the Social Service Director's office, either nurses' station, or the activity room.There was one grievance note on a desk in the main front lobby, but no blank forms or other grievance material was found. On 9/10/25 at 10:26 a.m., a meeting was conducted with the Resident Council President and 3 other residents who regularly attended the Resident Council Meetings. When asked about how to file a grievance and if there were grievance forms accessible, the meeting consensus was no, there was no good way to file a grievances confidentially. The residents indicated, hopefully they and other residents would feel comfortable enough to let staff know and have the grievance filed on their behalf. On 9/10/25 at 10:50 a.m., LPN 4 indicated she did not know where any grievance forms were and had not seen any at the nurses' station. On 9/10 25 at 10:55 a.m., QMA 8 indicated since she had started working, she had not noticed or seen where any grievance forms were located. But from her previous facility experience she knew they were supposed to be accessible for residents to get without assistance at all times. On 9/20/15 at 10:57 a.m., an Activity Assistant indicated there were no grievance forms in the Activity room to his knowledge, and he did not know where else to look for them except in the Social Service Director's office, or maybe in the copier room. On 9/10/25 at 11:00 a.m., the DON checked the front lobby, the copier room, and front nurses' station. Grievance forms were not available. During an interview on 9/10/25 at 11:02 a.m. the Regional Clinical Consultant indicated grievance forms should always be accessible to the residents. On 9/10/25 at 1:50 p.m., the Administrator provided a copy of current facility policy titled, Grievance/Complaints/Missing Property, dated November 2016. The policy indicated, .It is the policy of the facility to see that the residents and their responsible parties are made aware upon admission and as indicated of the resident's rights to express a complaint or grievance orally, or in or in writing at any time this complaint or grievance may also be done anonymously. there will be posted information throughout the facility in prominent locations as to the resident individual right to express a complaint or a grievance in writing or anonymously as well as the contact information for the person (Grievance Official) in the facility who should be in receipt of the concern or complaint. 3.1-7(a)

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff were available to answer call lights in a timely and appropriate manner as evidenced by delayed call light response times, residents left waiting for toileting assistance, residents left on bedpans, staff and resident interviews reporting inadequate staffing levels. This deficient practice had the potential to effect 43 of 43 residents who resided in the facility and received nursing care. Findings include:Upon the survey entrance on 9/7/25 from 9:40 a.m. until 10:30 a.m., the following was observed: No administrative staff were present, and the Manager on Duty/Charge Nurse was busy working on the floor as a nurse passing medication. Several call lights were illuminated, flashing, and sounding throughout the building. Licensed Practical Nurse (LPN) 4 indicated she was the only nurse in the building at that time, with two Qualified Medication Aides (QMAs) who were helping pass medications. There were only three Certified Nursing Aides (CNAs) who were all busy with other residents at that time, which was why so many call lights were on. On 9/7/25 at 9:50 a.m. the bathroom call light was on in Resident 18's room at this time CNA 11 was observed going into Resident 18's room and shutting the call light off. On 9/7/25 at 10:00 a.m. the bathroom call light in Resident 18's room came back on and loud banging on the wall was heard coming from the room. On 9/7/25 at 10:05 a.m. QMA 5 indicated it was Resident 18 banging on the wall. She indicated he did that sometimes when he got excited about football. At this time CNA 9 went into Resident 18's room and shut the bathroom call light off. On 9/7/25 at 10:30 a.m. Resident 18 indicated CNA 11 came in and said she was just going to get supplies and would be back. Resident 18 indicated CNA 11 shut the bathroom call light off but did not come back. He indicated CNA 11 was not his assigned aide, CNA 9 was. Resident 11 indicated staff did this all the time, they would say it wasn't their hall and he would have to wait until his aide was available. He indicated he wouldn't have been beating on the wall if they wouldn't have come in and said they were coming back when they weren't. On 9/7/25 at 10:45 a.m. LPN 4 was observed as she went into Resident 2s room to answer a call light. Resident 2 indicated to LPN 4 that he asked her to suction him and do a breathing treatment on him yesterday, but she didn't. LPN 4 indicated yesterday was a busy day and that she was sorry. Resident 2 indicated he had his call light on to get up out of bed for the church service. LPN 4 indicated his aide was coming soon, but she was busy right now so he would have to wait for his aide. LPN 4 shut the call light off and left the room. On 9/7/25 at 10:46 a.m. LPN 4 was observed conversing with other staff. After leaving the room with Resident 2. On 9/7/25 at 10:48 a.m. Resident 2 put his call light back on. The Activity Director walked by and asked if he wanted to get up for church services. LPN 4 indicated she had already talked to him and told him that he was next on the aides list to get up. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/7/25 at 10:50 a.m. CNA 11 was observed sitting at the nurses' station. LPN 4 observed speaking with ED who had just arrived. On 9/7/25 at 11:15 a.m. Resident 2 indicated staff were always on their phones while call lights were going off, and staff often came in. During an interview on 9/7/25 at 11:05 a.m., Resident 12 indicated the staff were all very good to her and she loved them all dearly, but felt bad for the aides because they worked so hard and did not have enough help. Resident 12 was able to meet most of her own needs, but at times had waited up to an hour for her call light to be answered. During an interview on 9/7/25 at 11:10 a.m., QMA 8 indicated the facility was very short staffed, especially on the weekends and like today there were only three CNAs trying to get everything done for everyone. QMA 8 indicated she was passing medication that morning and tried to help the aides when she could, but also did not want her medication administrations to be late. On 9/7/25 at 11:19 a.m., the Activity Director (AD) stopped Resident 7 and encouraged him to change his shirt, which was observed to have old food and beverage stains. The AD indicated, let's go change your shirt, this looks like it's from Friday. During a continuous observation, on 9/7/25 from 11:20 a.m. until 11:42 a.m., the following was observed: At 11:20 a.m., Resident 31's call light was activated. At 11:34 a.m., the Activity Director (AD) went to Resident 31's door and called into him, What do you need? In reply to the resident's answer the AD indicated back, your aides are busy, you'll have to wait a couple minutes. At 11:38 a.m., CNA 11 came running out of another resident's room with a bag of trash that she disposed of, then went to Resident 31's room and to turn off the light. During an interview at 11:40 a.m., CNA 11 indicated Resident 31 wanted to get up for lunch, but he required at least two people to transfer so she needed to wait for help. At that time the Medical Records Coordinator (MRC) indicated she would go and help. At 11:50 a.m., Residents 31 was observed as he propelled himself in his electric scooter up the hall to the dining room. During a continuous observation, on 9/8/25 from 9:50 a.m., until 10:30 a.m., the following was observed: On 9/8/25 at 9:51 a.m., Resident 28 was observed in his electric scooter in the doorframe of his room and appeared to be waiting. At that time, LPN 4 indicated she was passing medication and the two CNAs were in with another resident who required, care-in-pairs (two staff members of care) and was very time consuming. LPN 4 indicated Resident 28 was waiting for a shower. At 10:14 a.m., the MRC stopped and asked Resident 28 what he needed. Resident 28 indicated he was waiting for a shower. The MRC indicated the aides were passing ice water, but would get to him as (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	soon as they could. At 10:20 a.m., CNA 9 asked CNA 11 if she could get Resident 28 in the shower, and she would go start on Resident 31. CNA 11 agreed and went to gather supplies as CNA 9 went to Resident 28's room. At 10:30 a.m., CNA 11 assisted Resident 28 into the shower room. During a continuous observation, on 9/8/25 from 10:30 a.m., until 10:47 a.m., the following was observed: At 10:30 a.m., LPN 4 was charting at the nurses' cart when the Assistant Director of Nursing (ADON) came down and indicated she wanted to go through the cart. LPN 4 handed over the keys and indicated she would go take a break while the ADON was on the cart. At 10:35 a.m., Resident 21's call light illuminated. At that time, CNA 11 was assisting a resident in the shower, and CNA 9 was assisting another resident in their room. At 10:41 a.m., the ADON stopped CNA 11, who had just exited the soiled utility room and told her to go check who light was on, but by that time, the Director of Nursing (DON) was at Resident 21's door and went in. She turned off the light and came to the nurses' station and asked CNA 11 to go help. During an interview at 10:43 a.m., the DON indicated Resident 21 would not wait for staff to assist him to the bathroom and he would often take himself, which would cause him to have accidents and his urine would wind up on the toilet seat, on the floor in front of him, and sometimes soil his clothes. At 10:47 a.m., CNA 11 had gathered supplies and went into Resident 21's room to assist him. On 9/8/25 at 10:52 a.m., CNA 9 exited Resident 31's room and came to the utility room to throw away soiled linen. She appeared out of breath and sweaty. Resident 21 was in the hallway and asked her a question, CNA 9 indicated with an exacerbated but apologetic tone, it's going to have to wait until after lunch, we're too busy. During an interview on 9/8/25 at10:53 a.m., CNA 9 indicated she needed to take a break because she was exhausted. She indicated her assignment was from rooms 101-117 by herself and they were all very heavy residents (meaning, required a lot of time, attention and assistance). She indicated Resident 31, who she had just finished with, required the use of a slide board for transfers, and staff had to do all the work for him. Another resident, who required two aides at all times due to behaviors, was also very particular and time consuming which left the floor short of staff because sometimes they would have to be in with her for over an hour to get everything right for her. The other aide helped when she could, but she also had a heavy load from rooms 118 and down. It's hard and some days they could not get it all done. During a continuous observation on 9/8/25 from 12:23 p.m., until 1:00 p.m., the following was observed: At 12:23 p.m., the call light for Resident 4 was activated. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 12:44 p.m., the Administrator (ADM) stopped at Resident 4's room and asked what she needed and the light was turned off. At 12:47 p.m., CNA 11 asked LPN 4 for assistance getting another resident into bed. At 12:50 p.m., Resident 4 was observed in her bed, her eyes were closed but she awake at the sound of her name. She indicated, she needed to be taken off the bedpan, and didn't realize she had fallen asleep while waiting. She did not know her call light had been turned off. At 1:00 p.m., LPN 4 was informed that Resident 4's call light had been turned off a while ago and she still needed to be assisted off the bedpan. LPN 4 went to assist the resident and the two aides were busy with other residents and other staff members were assisting residents out for a smoke break. During a continuous observation on 9/8/25 from 1:20 p.m. until 1:54 p.m., the following was observed: At 1:20 p.m., CNA 9 exited Resident 1's room and gave report to LPN 4 that the Resident reported she did not feel well and wanted to go to the hospital. CNA 9 described how Resident 1 seemed to be gagging in an attempt to vomit and reported that her stomach and head hurt. LPN 4 did not go to assess Resident 1. At 1:54 p.m., CNA 11 indicated Resident 1 was still not feeling well and wanted to go to the hospital. At this time, LPN 4 went to assess Resident 1. At 1:57 p.m., the DON came to the nurses' station and LPN 4 reported Resident 1's vital signs were within normal limits but she still requested to go to the hospital. The DON advised to go ahead and send her out 911. During a continuous observation on 9/9/25 from 12:50 p.m. until 12:57 p.m.: At 12:50 p.m., Resident 25 was seated in her wheelchair at the nurses' station. LPN 13 was seated behind the nurses' station and worked on the computer. At this time, Resident 25 asked for some tissues and indicated her nose was running. LPN 13 did not hear her, or did not answer, but QMA 8 passed by and indicated she would try to find the resident some tissues. At 12:53 p.m., Resident 25 requested tissues for a second time. At 12:55 p.m., Resident 25 requested tissues for a third time, and without a response, she stood unsteadily from her wheelchair and attempted to walk up to the nurses' station. Only then, did LPN 13 jump up and immediately requested that the resident sit back down so she would not fall. At 12:57 p.m., Resident 25 asked for tissues and LPN 13 went to find some. On 9/10/25 at 10:26 a.m., a meeting was conducted with the Resident Council President and three other residents who regularly attended the Resident Council Meetings. When asked about staffing and call light response time, the meeting consensus was that the facility was short staff for the CNAs and needed more CNA help especially on the weekends. The residents indicated they often waited for a very long time to get assistance and one of their biggest concerns was, the staff would come in the room, turn off the light and say they would come back, but never did. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/11/25 at 10:52 a.m., the AD came to the front offices and called down the hall, can anyone come help me, these call lights are going off like Christmas lights. On 9/8/25 to 10:37 a.m. the DON indicated if an aide or nurse went into a room and a resident had a need they were expected to help that resident whether they were assigned to that resident or not. She indicated staff should not turn a call light off unless the residents needs were met. On 9/10/25 at 1:50 p.m., the Administrator provided a copy of current facility policy titled, Standard Supervision and Monitoring, dated 11/25/11. The policy indicated, This guideline emphasizes a proactive intervention promoting enhanced physical and psychosocial well-being. The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the resident's physical and psychosocial needs. Staff assignments are based on the resident needs as far as their acuity and their assessment results and their person-centered care planning. On 9/11/25 at 11:25 a.m., the Administrator provided a copy of current facility policy titled, Call Light, Use of, dated 1/1/20. The policy indicated, Procedure Purpose: to respond to resident's call light for assistance. All facility personnel must be aware of call lights at all times. Answer ALL call lights promptly whether or not you are assigned to the resident answer the call lights in a prompt, calm, courteous manner; turn off the call light as soon as you enter the room. Never make the resident feel you are too busy to give assistance. 3.1-17(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to send adequate documentation with a resident to the hospital and failed to reconcile a resident's medications, who was discharging to his home for 2 of 3 residents reviewed for discharge (Resident 44 and Resident 46). Findings include:1. On 9/8/25 at 11:37 a.m., a record review was completed for Resident 46. He had the following diagnoses which included but were not limited to chronic respiratory failure, diabetes, neuropath (weakness, numbness, and pain from nerve damage, usually in the hands and feet), major depressive disorder, gastro-esophageal reflux disease (GERD) (a digestive disease in which stomach acid or bile irritates the food pipe lining), and anxiety disorder. Resident 46 was discharged home on 8/17/25. His record lacked documentation of his medications that were sent home with him, except hydrocodone (a pain medication) and hydroxyzine (an anti-itch medication). The medications lacking reconciliation were amitriptyline (an antidepressant), amlodipine (for high blood pressure), aripiprazole (for depression), ascorbic acid (vitamin C), atorvastatin (for high cholesterol), Plavix (for blood clots), docusate sodium (for constipation), ferrous sulfate (iron), Humalog (an insulin), insulin glargine (for diabetes), Jardiance (for diabetes), losartan (for hypertension), metformin (for diabetes), metoprolol (for high blood pressure), and oxybutynin (for overactive bladder), paroxetine (for depression), and tamsulosin (for enlarged prostate). On 9/11/25 at 10:35 a.m., the Regional Nurse Consultant (RNC) indicated the nurse sent Resident 46's medications home with him, but they could only find where the disposition of hydrocodone and hydroxyzine were documented. 2. On 9/8/25 at 12:12 p.m., a record review was completed for Resident 44. She had the following diagnoses which included but were not limited to cerebral infarction (a condition where blood flow to the brain is interrupted, leading to damage or death of brain cells), acute renal failure, cerebral edema (a condition where excess fluid accumulates in the brain tissue, causing it to swell), subarachnoid hemorrhage (SAH) (a bleeding into the space between the brain and the thin membrane ([NAME] mater) that covers it), weakness, and GERD. Resident 44's record lacked a discharge summary to include pertinent information regarding resident's current health along with past health concerns, code status, and physician orders. On 12/10/25 at 10:32 a.m. the Regional Nurse Consultant (RNC) indicated Resident 44 was sent out with swelling to the right side of her head. She indicated a SBAR (Situation Background Assessment and Recommendation) was completed in the progress notes but she could not find any discharge information that was sent with the resident to the hospital. A policy titled, Guidelines for Discharge/Transfer, was provided by the Director of Nursing (DON) on 9/10/25 at 9:24 a.m. It indicated, .Types of discharges for reference: higher level of care (emergency or planned hospital transfer), completed transfer form in electronic health record (EHR)- EHR discharge/transfer form, send face sheet, send advanced directives, send MAR/TAR (Medication Administration Record/Treatment Administration Record, other pertinent information or required information as per state regulations. 3.1-12(a)(4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to accurately code a Minimum Data Set (MDS) for types of medications used by the residents for 2 of 5 residents reviewed for MDS accuracy (Residents 51 and 41). Findings include:1. On 9/9/25 at 1:52 p.m., a record review was completed for Resident 51. She had the following diagnoses which included, but were not limited to, bipolar disorder (a mental illness that causes clear shifts in a person's mood, energy), allergies, constipation, pain, and anxiety. Resident 51 had an MDS dated [DATE]. Section N (Medications used) indicated she did not take an antianxiety medication. A physician order, dated 4/21/25, indicated Resident 51 took Ativan (an antianxiety medication) 0.5 mg (milligrams) two times daily. A care plan, dated 9/8/25, indicated she was at risk for increased anxiousness related diagnoses with need for anxiolytic (antianxiety). The goal indicated she would have no adverse reactions related to anxiolytic use. 2. On 9/9/25 at 1:45 p.m., a record review was completed for Resident 41. He had the following diagnoses which included, but were not limited to, generalized edema (swelling), gastro-esophageal reflux disease (GERD) (stomach reflux), weakness, repeated falls, and diabetes. Resident 41 had a MDS, dated [DATE], Section N indicated he did not take an anticoagulant (medications that prevent blood from clotting). It indicated he took an antiplatelet (medications that prevent platelets from clumping together and forming blood clots). A physician order, dated 5/9/24, indicated Resident 41took Eliquis (an anticoagulant) 2.5 mg two times daily for an antiplatelet. A care plan, dated 9/1/19, indicated he was at risk for bleeding related anticoagulant use. The goal was he would have no adverse reactions with the use of anticoagulants. An intervention indicated that staff would administer his medications as ordered. On 9/10/25 at 1:32 p.m., the Regional Nurse Consultant (RCS) indicated the MDS for both residents had been corrected. They did not have a policy for accuracy of assessments. They followed the RAI (Resident Assessment Instrument).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to prevent the potential for accidents when medications were left at bedside and the resident was not supervised to take his medications for 1 of 1 random observation (Resident 33). Findings include: On 9/8/25 at 12:53 a.m., a record review was completed for Resident 33. He had the following diagnoses which included, but were not limited to, alcoholic cirrhosis of the liver with ascites (a condition where excess fluid accumulates in the abdominal cavity, causing swelling and bloating), major depression, difficulty in walking, and low blood pressure. On 9/7/25 at 10:38 a.m., it was noted that Resident 33 had a cup of medications on his bedside table. Resident 33 indicated he did not take his medications because he was nauseous and would take them later. Resident 33's medical record lacked an assessment for him to self-administer his own medications. A review of resident's medication record indicated he took the following medications in the morning hours.a.) Ciprofloxacin HCl (an antibiotic) oral tablet 500 milligrams (mg) daily.b.) Folic Acid (a supplement) 1mg dailyc.) Furosemide (a diuretic) 40 mg dailyd.) Spironolactone (a diuretic) 50 mg dailye.) Thiamine (a supplement) 100 mg dailyf.) Zinc Sulfate (a supplement) 220 mg dailyg.) Promethazine (used for nausea) 25 mg two times dailyh.) Rifaximin (used to treat cirrhosis) 500 mg two times dailyi.) Midodrine (used to treat low blood pressure) 5 mg, 3 tablets The Director of Nursing (DON) was made aware of the medication being left at bedside. She indicated she educated QMA 5 regarding leaving medications at bedside for residents who had not been assessed to leave their medications at bedside. A policy titled, Medication Storage in the Facility was provided by the DON on 9/10/25 at 9:25 a.m. It indicated, .Residents who have been trained in self-administration will have access only to their individual drug supply. 3.1-45(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure the correct prescribed solutions were used for 3 of 8 peritoneal dialysis treatments, and failed to follow appropriate infection control measures to properly and timely dispose of the used dialysate (fluid pulled off during the dialysis treatment) (Resident 47). Findings include:On 9/9/25 at 9:50 a.m., Resident 47 was observed in his room. There was a bag of fluid left on his bedroom floor, that had leaked some fluid onto the floor. Resident 47 indicated he had just come off his dialysis treatment about 30 minute prior and the nurse had not disposed of the effluent fluid (bio-hazard waste material). There were two empty solution bags left on top of the dialysis cart. During an interview, Resident 47 indicated it seemed like the nurses were doing good with his dialysis, especially since they had all recently been trained on the treatment process. Resident 47 indicated he had to give them some reminders during his treatment but mostly relied on the staff as his current treatment plan was different from what he had been used to at home. On 9/9/25 at 10:30 a.m., Resident 47's medical record was reviewed. He was a short-term rehab resident. He had current diagnoses which included, but were not limited to, end stage renal disease and dependence on peritoneal dialysis. He was admitted to the facility 8/28/25 with new physician orders from his dialysis provider which indicated the following detailed and specific instructions: Target Weight: 229 lbs [pounds]. If weight is 229.0 lbs and under, use two yellow (1.5%) bags.If weight is 229.10233 lbs, use one green (2.5%) and one yellow (1.5%) bags.If weight is 233.1-236 lbs, use two green (2.5%) bags.If weight is 236.1-239 lbs, use one red (4.25%) bag and one green (2.5%) bag. If weight is 239 lbs, call dialysis clinic for further orders.If SBP (top blood pressure number) is below 110 before treatment, use two yellow (1/5%) bags, regardless of weight. These physician's order were on a printed piece of paper in the resident's room, but were not electronically entered into his medical record until 8/30/25. Resident 47's daily dialysis logs were reviewed and revealed the following: On 9/2/25, he weighed 231.3 lbs, his blood pressure was 132/64 and he was administered 2 yellow bags, which was a discrepancy to his parameter orders as he should have received one yellow and one green. On 9/5/25, he weighed 224.2 lbs, his blood pressure was 122/60 and he was administered 1 green and 1 yellow bag, which was a discrepancy to his parameter orders as he should have received 2 yellow bags. On 9/6/25, he weighed 224 lbs, his blood pressure was 158/78 and he was administered 1 green and 1 yellow bag, which was a discrepancy to his parameter orders as he should have received 2 yellow bags. On 9/10/25 at 10:18 a.m., the Director of Nursing (DON) provided a copy of recent nurse training and education on Peritoneal Dialysis. The education included skill validation to properly dispose and store contaminated or infectious waste (the pulled effluent) and how to properly end a treatment and dispose of the effluent fluid. During an interview on 9/10/25 at 10:20 a.m., the DON indicated the drained effluent needed to be measured and disposed of at the completion of the treatment session, and the parameters needed to be followed closely as prescribed as not to cause the potential for side effects or poor treatment outcomes. On 9/10/25 at 10:18 a.m., the DON provided a copy of current facility policy titled, In Peritoneal Dialysis. dated 2/4/25. The policy indicated, .Peritoneal dialysis is a method for removing waste products from the blood. During peritoneal dialysis, a cleansing fluid flows through a tube into part of the stomach/abdominal area. The inner lining of the abdomen- also known as the peritoneum, acts as a filter and removes waste products from the blood. After a certain amount of time, the fluid with the filtered waste flows out of the abdomen and is discarded appropriately. Any type of dialysis must have a detailed and specific physician's order. when drain is complete, cap transfer set with mini cap as per protocol or capping off procedure. assess appearance, color and clarity of drained effluent. measure drained effluent. 3.1-37(a)

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	155211	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Lebanon, The	1585 Perry Worth Rd Lebanon, IN 46052

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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	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. Based on observation, record review, and interview, the facility failed to ensure nursing staff had the necessary skills to administer a resident's medication and administer the right dose to a resident (Resident 24). Findings include:On 9/7/25 at 12:26 p.m., Qualified Medication Aide (QMA) 5 was setting up Resident 24's and Resident 23's medication at the same time. She indicated she could not find Resident 24's acetaminophen (a pain medication) medication and sent Licensed Practical Nurse (LPN) 4 to look for his medication in the medication room. LPN 4 came back with Resident 23's acetaminophen. The dosage was 325 milligram (mg). QMA 5 indicated they shared Resident 23's and 24's medications sometimes because the residents were married. QMA 5 was instructed that Resident 24's ordered acetaminophen dose was one 500 mg tablet three times daily and not 325 mg. QMA 5 indicated if she gave him two tablets that would be a dose of 650 mg and proceeded to administer Resident 24 one 325 mg tablet. This was short 175 mg for his ordered 500 mg tablet. On 9/11/25 at 1:00 p.m., the Regional Clinical Director (RCD) indicated she found the 325 mg acetaminophen in the cart for Resident 23 and removed it from use since Resident 23's dose ordered was 500 mg. The RCD indicated QMA 5 was counseled regarding incident. A policy titled, Medication Error Reporting, was provided by the Director of Nursing (DON) on 9/10/25 at 9:25 a.m. It indicated, .The facility will notify the appropriate personnel at the pharmacy when a medication error has occurred via phone call or email. 3.1-14(i)

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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 observations and interviews, the facility failed to date medications and remove expired medications from use for 1 of 2 medication carts and 1 of 2 medication rooms. Findings include:On 9/725 at 11:20 a.m., the 100 hall medication cart was observed. Inside the top drawer of cart eye drops were being stored with nitroglycerin, ear, and oral medications. Qualified Medication Aide (QMA) 8 indicated she would correct and store medications separately. The following medications were found without a date or were expired.a. Resident 2 had two bottles of fluticasone nasal sprays (used to treat allergies) without a date to indicate when they were opened. He had ear drop solution 6.5% with no date to indicate when opened on the bottle. He had an inhaler flutic/vilan 100-25 mcg with no date to indicate when it was opened.b. An ellipta inhaler was in the cart with no name or date on it.c. Resident 31 had three bottles of fluticasone without a date to indicate when they were opened.d. Resident 14 had two bottles of fluticasone with a date to indicate when they were opened.e. Resident 1 had a bottle of fluticasone with a date to indicate when it was opened.f. A bottle of fluticasone was in the cart without a name or date on the bottle.g. Resident 28 had a bottle of latanoprost (used to treat glaucoma) with a date to indicate when opened. It was sent from the pharmacy on 4/3/25. h. Resident 4 had a flutic/salm discus (used to treat asthma) without a date on the diskus.i. Resident 3 had an insulin pen of lantus expired on 9/4/25. On 9/7/25 at 11:40 a.m., QMA 8 indicated she would remove the items from the medication cart and reorder said medications. A policy titled, Medication Storage in the Facility, was provided by the Director of Nursing (DON) on 9/10/25 at 9:25 a.m. It indicated, .Eye drops, ointments, drops and inhalers are to be kept separate from other medications.Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled, or without secure closure will immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures and reordered from the pharmacy if a current order exists. 3.1-25(j)3.1-25(m)3.1-25(n)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews and record review, the facility failed to ensure accurate documentation related to wound care orders for a pressure ulcer and administration of a controlled substance for 1 of 19 Residents reviewed for accurate documentation (Resident 2). Findings include:1. On 9/9/25 at 12:06 p.m. Resident 2's medical record was reviewed. He was a long-term care Resident 2's diagnoses included, but were not limited to, acute and chronic respiratory failure, stage 4 pressure ulcer (a pressure wound over the tailbone, that involves full-thickness tissue loss, exposing muscle, tendon, or bone) to the sacral area, post traumatic stress disorder (PTSD), and anxiety. Resident 2's physician orders indicated Resident 2 had an order for Lorazepam 0.5 milligram (mg) oral tablets, give one tablet by mouth every 8 hours as needed (PRN) for anxiety. An order for Lorazepam 0.5 mg oral tablets, give 0.5mg by mouth every 8 hours PRN for anxiety. An order for Hydroxyzine 25 mg oral tablets, give 25 mg by mouth every 6 hours PRN for anxiety. None of these orders had a stop date. A medication review, dated 7/10/25, indicated Resident 2 had an order for Hydroxyzine 25 mg every 8 hours as needed for anxiety. The recommendation was to either discontinue the medication or add a stop date to the PRN for short-term use. Neither of the options were checked off and the only response was note written to physician under follow-through. Resident 2's Medication Administration Record (MAR) indicated on 9/3/25 the order that said Lorazepam 0.5 mg oral tablets, give 0.5 mg by mouth every 8 hours PRN for anxiety was marked as given and effective at 9:42 p.m. and the order that said Lorazepam 0.5 mg oral tablets, give one tablet by mouth every 8 hours as needed (PRN) for anxiety was marked as given and effective at 9:43 p.m. The MAR indicated on 9/9/25 the order that said Lorazepam 0.5 mg oral tablets, give 0.5 mg by mouth every 8 hours PRN for anxiety was marked as given and effective at 11:55 a.m. and again at 3:44 p.m., and the order that said Lorazepam 0.5 mg oral tablets, give one tablet by mouth every 8 hours as needed (PRN) for anxiety was marked as given and effective at 4:09 p.m. On 9/10/25 at 9:34 a.m. the narcotic book and the Lorazepam card were observed. All pills were accounted for and appropriately signed off in the narcotic book. During an interview on 9/10/25 at 9:15 a.m. the Director of Nursing (DON) indicated the Lorazepam orders for Resident 2 were duplicate orders. The DON indicated she talked to Licensed Practical Nurse (LPN) 12 who charted that she gave both ordered doses in the MAR and she indicated she did not give both doses, she clicked both on accident but did not give both. 2. On 9/9/25 at 12:06 p.m. Resident 2's medical record was reviewed. He was a long-term care Resident 2's diagnoses included, but were not limited to, acute and chronic respiratory failure, stage 4 pressure ulcer (a pressure wound over the tailbone, that involves full-thickness tissue loss, exposing muscle, tendon, or bone) to the sacral area, post traumatic stress disorder (PTSD), and anxiety. A physician order, dated 7/29/25, for wound care indicated staff should cleanse the sacral wound with normal saline, pat dry, apply Hydrofera blue (a non-cytotoxic antibacterial foam wound dressing made of polyvinyl alcohol (PVA) sponge containing methylene blue and gentian violet), skin prep the surrounding tissue and secure with a bordered foam dressing every 3 days and PRN for soilage. A Nurse Practitioner (NP) wound assessment report, dated 8/29/25, indicated the wound measured 7 centimeters (cm) long, 8 cm wide and 0.7cm deep. The report indicated the wound was 50% epithelial tissue (one of the four basic types of human tissue, covers body surfaces, lines cavities and organs, and forms glands) and 50% granular tissue (a type of new, soft connective tissue that forms in response to injury or inflammation). The report also indicated the wound edges were attached and it did not mention any undermining or tunneling. A weekly skin check, dated 9/4/25, indicated Resident 2 did not have a loss of skin integrity. A weekly wound evaluation, dated 9/5/25, indicated the current wound care orders as of 8/29/25 were cleanse with normal saline, pat dry, skin prep to surrounding tissue, apply Calcium Alginate with Silver (a highly absorbent wound dressing made from natural seaweed fibers (alginate) that also contains antimicrobial silver particles) to the wound bed, secure with an abdominal (ABD) pad and secure with (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tape. The record lacked documentation of a physician order for the recommended wound treatment. On 9/11/25 at 10:00 a.m. the DON provided an ER note, dated 9/5/25, that indicated the wound measured 8.3 cm long, 6 cm wide, and 0.5 cm deep. The note indicated the wound was between 25% and 50% granular tissue and between 25% and 50% slough (non-viable, yellow or white, devitalized tissue composed of fibrin, dead cells, proteins, and sometimes bacteria or biofilms). The note also indicated there was undermining that measured 0.4 cm deep from 3 o'clock to 5 o'clock and a second undermining that measured 0.5 cm deep from 6 o'clock to 7 o'clock. On 9/9/25 at 1:43 p.m. the DON indicated the wound nurse, which was the current ADON, would go around with the NP and the wound nurse was responsible for putting any new orders for wound treatments into the resident's medical record. On 9/11/2025 at 9:48 a.m. the DON indicated the ADON had just started in July, so she wasn't well versed on the process of putting in new orders when doing wound rounds with the NP. She indicated they did wound rounds every Friday with the wound NP. The ADON should have taken paper with her while they go around to take notes. Then the wound NP should tell them what she wants ordered, and then the NP would put in her note either that day or the following Monday. The DON indicated the ADON was told one thing about the orders and the NP put something else in her note. On 9/11/25 at 10:00 a.m. the DON provided a copy of a current facility policy titled, SWAT Program Skin, Weight, Assessment Team program, dated 10/9/23. This policy indicated, . System for providing care once wound is identified. upon receipt of the order- immediate transcription of the order onto MAR/TAR. On 9/10/25 at 2:30 p.m. a policy pertaining to accuracy of documentation was requested. No policy pertaining to documentation was provided at exit. 3.1-3(o)3.1-3(r)