

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER Waters of Huntingburg, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 Leland Dr Huntingburg, IN 47542	

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)
<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39130</p> <p>Based on observation, interview and record review, the facility failed to ensure adequate staff was available on a locked dementia unit. A licensed nurse was not stationed on the unit during 2 of 2 days during the survey, monitoring and documenting of behaviors was not being completed during a 30-day review period, and staffing patterns did not meet the facility's Alzheimer's/Dementia Special Care Unit staffing specifications. (Memory Springs unit, Resident C, Resident D)</p> <p>Findings include:</p> <p>1. During an observation and interview 2/4/25 at 9:50 A.M., LPN 2 entered Memory Springs (locked dementia unit). LPN 2 checked in and then exited then unit. One Certified Nurse Aide (CNA) 5 and one activity assistant (AA) 3 were on the Memory Springs unit. CNA 5 indicated that the Memory Springs unit nurse floated from the front hall located at the front of the building. The nurse or other staff come on the unit periodically to check in, administer medications, or will come to the unit if needed and contacted by the CNA.</p> <p>During a review of the daily schedule for 2/4/25, no nursing staff and no Qualified Medication Aide (QMA) were assigned to the Memory Springs locked dementia unit during day shift, evening shift, or night shift. One CNA was assigned to the unit during the day, evening, and night shifts.</p> <p>A review of the facility census, on 2/4/25, indicated there were nine residents that resided on the Memory Springs locked dementia unit.</p> <p>During a confidential interview on 2/4/25, a nursing staff member indicated while working the front hall of the building they have to float back to the Memory Springs locked dementia unit. The staff member indicated that nursing was not able effectively monitor the dementia unit and that the one CNA on the dementia unit could not keep up. The staff indicated the dementia unit should be staffed better.</p> <p>The facility's Alzheimer's / Dementia Special Care Unit dementia disclosure form dated, 12/30/24, indicated, the resident census and number of full time equivalent (FTE) direct care staff for each shift of the dementia care program / unit: (one FTE = 8 hours) At that time, the dementia unit census was 10. The form indicated the following staffing patterns:</p> <p>Day / Morning - 1 LPN, 1 CNA, 1 QMA, 1 activity staff, 1 social worker</p> <p>(continued on next page)</p>

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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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Afternoon / Evening - 0.5 LPN, 1 CNA, 1 QMA, 0.5 activity staff</p> <p>Night - 1 LPN, 1 CNA</p> <p>A review of the facility's daily staffing schedule from 1/22/25 through 2/4/25 indicated that no nurse or QMA was assigned to the Memory Springs locked dementia unit during the day shift. One QMA was assigned to the unit from 7:00 P.M. - 7:00 A.M. on 1/25/25, 1/26/25, 2/1/25, and 2/2/25. On those dates that a 7:00 P.M. - 7:00 A.M. QMA was scheduled to the unit, no CNA was scheduled to be on the unit during that time frame.</p> <p>During an observation on 2/5/25 at 9:35 A.M., AA 3 was sitting at a table with a resident in a common activity area. AA3 indicated the CNA was assisting a resident with bathing. No other staff were on the unit until 9:37 A.M. when the Administrator in Training (AIT) came onto the unit and sat with another resident in the common area. The Facility Administrator along with other staff members then came onto the unit.</p> <p>2. During an interview on 2/4/25 at 9:55 A.M. CNA 5 indicated that she had to watch Resident C because he liked to joke around on the dementia unit and the other residents did not realize he was joking.</p> <p>Resident C's diagnoses included, but were not limited to, Alzheimer's disease, vascular dementia with mood disturbance, cognitive communication deficit, and anxiety.</p> <p>Resident C's most recent quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident had severe cognitive impairment, and wandered daily.</p> <p>Resident C's physician orders included, but were not limited to, behavioral monitoring every shift for depression, withdrawn, anxiety, pacing (started 8/23/24), reside on secure unit due to Alzheimer's dementia (started 9/25/24), and cimetidine 300 milligrams (mg) one time a day for sexual behaviors (ordered 1/21/25).</p> <p>Resident C's CNA charting from 1/6/25 to 2/4/25 indicated Resident C had the following behaviors on the following dates:</p> <p>1/21/25 at 5:59 A.M. - Resident was physically aggressive towards others, expressed frustration / anger at others, and displayed public sexual acts.(no specific sexual acts were documented)</p> <p>1/27/25 at 4:28 A.M. - Resident displayed public sexual acts,(no specific sexual acts documented) was anxious / restless, and was wandering.</p> <p>2/2/25 at 11:01 A.M. - Resident displayed public sexual acts (no specific sexual acts documented)</p> <p>A facility investigation timeline, signed by the Facility Administrator and Director of Nursing (DON) and dated 1/15/25 indicated, on 1/15/25 the DON was told by CNA 5 that Resident C was demonstrating sexually inappropriate behaviors the night prior. The DON questioned the MDS nurse, who had been the charge nurse for the building during the night of 1/14/25, about Resident C's behavior. The MDS nurse indicated that the CNA on the Memory Springs locked dementia unit had informed her that Resident C was making sexually inappropriate comments to staff during the night shift.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident C's nurse's notes contained no documentation of sexually inappropriate behaviors on 1/14/25, 1/15/25, 1/21/25, 1/27/25, or 2/2/25.</p> <p>3. On 2/4/25 at 12:00 P.M., a review of a facility investigation timeline, signed by the Facility Administrator and Director of Nursing (DON) and dated 1/15/25 indicated, on 1/14/25 the MDS nurse was called to the Memory Springs locked dementia unit at 8:16 P.M., to assist in locating Resident D after the CNA assigned to the unit could not locate the resident. Resident D was found in another resident's room, in their bed, asleep with the resident.</p> <p>Resident D's diagnoses included, but were not limited to, altered mental status, dementia with behavioral disturbances and psychotic disturbances, and Alzheimer's disease.</p> <p>Resident D's most recent annual MDS assessment, dated 1/6/25, indicted the resident had severe cognitive impairment and displayed behavioral symptoms directed towards others.</p> <p>Resident D's physician orders included, but were not limited to, behavioral monitoring every shift (started 2/21/24).</p> <p>Resident D's care plan included, but was not limited to, resident is at high risk for wandering due to dementia with behaviors (initiated 3/18/24), resident is at risk for decline in mood due to depression (initiated 2/14/24). An intervention included monitor for effectiveness of medications and interventions.</p> <p>Resident D's CNA charting indicated, on 1/21/25 at 7:33 A.M., Resident D was sad / tearful.</p> <p>Resident D's Treatment Administration Record (TAR) for January 2025, indicated the resident behavioral monitoring had been completed with the resident having no behaviors during the month of January, 2025.</p> <p>Resident D's nurse's notes contained no documentation of Resident D's behavior on the night of 1/14/25 or the resident's sadness / tearfulness on 1/21/25.</p> <p>During an interview on 2/4/25 at 1:20 P.M., LPN 11 indicated that if a resident is displaying a behavior, nursing staff should document the behavior in the resident's clinical record.</p> <p>During an interview on 2/5/25 at 12:15 P.M., the DON indicated that the facility did not have policy related to staffing.</p> <p>This citation relates to complaint IN00452251.</p> <p>3.1-17(a)</p> <p>3.1-17(c)(5)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39130</p> <p>Based on interview, and record review, the facility failed to provide necessary treatment and services for 2 of 3 residents reviewed for dementia care. Resident behaviors were not monitored and known behaviors were not documented by nursing staff. (Resident C, Resident D)</p> <p>Findings include:</p> <p>1. During an interview on 2/4/25 at 9:55 A.M. CNA 5 indicated that she had to watch Resident C because he liked to joke around on the dementia unit and the other residents did not realize he was joking.</p> <p>Resident C's diagnoses included, but were not limited to, Alzheimer's disease, vascular dementia with mood disturbance, cognitive communication deficit, and anxiety.</p> <p>Resident C's most recent quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident had severe cognitive impairment, and wandered daily.</p> <p>Resident C's physician orders included, but were not limited to, behavioral monitoring every shift for depression, withdrawn, anxiety, pacing (started 8/23/24), reside on secure unit due to Alzheimer's dementia (started 9/25/24), and cimetidine 300 milligrams (mg) one time a day for sexual behaviors (ordered 1/21/25).</p> <p>Resident C's care plan included, but was not limited to, resident demonstrates verbal inappropriate sexual comments due to dementia (initiated 1/21/25). One intervention was created prior to development of the care plan that included, redirect resident to room and offer toileting when making sexual comments (initiated 1/15/25).</p> <p>Resident C's CNA charting from 1/6/25 to 2/4/25 indicated Resident C had the following behaviors on the following dates:</p> <p>1/21/25 at 5:59 A.M. - Resident was physically aggressive towards others, expressed frustration / anger at others, and displayed public sexual acts (no specific sexual acts documented).</p> <p>1/27/25 at 4:28 A.M. - Resident displayed public sexual acts (no specific sexual acts documented), was anxious / restless, and was wandering.</p> <p>2/2/25 at 11:01 A.M. - Resident displayed public sexual acts(no specific sexual acts documented)</p> <p>A facility investigation timeline, signed by the Facility Administrator and Director of Nursing (DON) and dated 1/15/25 indicated, on 1/15/25 the DON was told by CNA 5 that Resident C was demonstrating sexually inappropriate behaviors the night prior. The DON questioned the MDS nurse, who had been the charge nurse for the building during the night of 1/14/25, about Resident C's behavior. The MDS nurse indicated that the CNA on the Memory Springs locked dementia unit had informed her that Resident C was making sexually inappropriate comments to staff during the night shift.</p> <p>(continued on next page)</p>		

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