STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntingburg, The	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure accurate receiving of routine medications for 1 of 3 residents reviewed for unnecessary medications. A physician's order was entered incorrectly which led to an interruption of a resident's routine medication and an unprescribed dosage reduction. (Resident B)Finding includes:A record review on 7/22/25 at 10:30 A.M., Resident B's diagnoses included, but were not limited to, unspecified polyneuropathy.Resident B's most recent quarterly Minimum Data Set (MDS) assessment, dated 4/15/25, indicated the resident had moderate cognitive impairment and received routine pain medication. Resident B's physician's orders included, but were not limited to; Lyrica Oral Capsule 100 milligrams (mg) give one (1) capsule two times a day for pain (started 5/10/24 and discontinued 6/24/25), Lyrica Oral Capsule 100 milligrams (mg) give two (2) capsules at bedtime related to polyneuropathy (started 11/5/24 and discontinued 6/24/25), Lyrica Oral Capsule 100 mg give one (1) capsule every morning and at bedtime for pain (started 6/24/25 and discontinued 6/28/25), Lyrica Oral Capsule 100 mg give one (1) capsule one time a day for pain (started 6/28/25 and discontinued 6/30/25), Lyrica Oral Capsule 100 mg give one (1) capsule one time a day for pain (started 6/30/25 and discontinued 6/30/25), Lyrica Oral Capsule 100 mg give two (2) capsules at bedtime (started 6/30/25 and discontinued 6/30/25), Lyrica Oral Capsule 100 mg give one (1) capsule one time a day and give one (1) capsule one time a day and give two (2) capsules at bedtime for pain (started 6/30/25).Resident B's medication administration record (MAR) for June 2025 indicated the resident did not receive a routine Lyrica 100 mg capsule at the ordered time of 12:00 P.M. on 6/23/25, did not receive the bedtime dose of 200 mg on 6/23/25, did not receive the morning dose of 100 mg on 6/24/25, and did not receive the noon dose of 100 mg on 6/24/25. Starting on 6/24/25 through 6/29/25, Resident B received only a 100 mg dose of Lyrica at bedtime and only received one 100 mg dose during the day.Resident B's progress notes included, but were not limited to: 6/24/25 at 5:15 A.M. - Lyrica oral capsule 100 mg held, will resume upon delivery, pharmacy and physician aware. 6/24/25 at 12:41 P.M. - Lyrica oral capsule 100 mg - Pharmacy stated they did not receive this. The hard script was faxed again today.6/24/25 at 6:24 P.M. - Resident's Lyrica did not arrive at the facility. Called the pharmacy to get information regarding this. The pharmacy stated the prescription had not been received. 6/29/25 at 12:09 A.M. - Resident complained of pain in legs during evening shift due to Lyrica reduction. 6/29/25 at 3:40 P.M. - Resident stated, My feet hurt so bad I can barely walk. The nurse stated to the resident that her Lyrica was decreased from four (4) capsules per day to two (2) capsules. The resident was unaware. Physician notified about the resident's complaint after reduction. 6/30/25 at 1:58 A.M. - Resident complained of foot pain at times due to Lyrica reduction.6/30/25 at 7:12 A.M. - Resident complained of leg and foot pain at times due to Lyrica reduction. Awaiting response from physician. 6/30/25 at 9:30 A.M. - Nurse practitioner clarified resident's Lyrica order - Lyrica 100 mg one capsule twice a day in the morning and at noon, and two capsules (200 mg) at bedtime. On 7/22/25 at 11:05 A.M., LPN 4 indicated Resident B's routine Lyrica order was changed from four capsules a day to two capsules a day by the facility without the physician's knowledge and without an order to do so. On 7/22/25 at 1:15 P.M., RN 6 indicated there was no order to change Resident B's Lyrica medication. An original order was being put into the electronic record and was entered incorrectly by facility staff. On 7/22/25 at 1:50 P.M., RN 6 supplied a facility policy titled Guideline for Physician Orders - (Following Physician Orders), dated 6/18/23. The policy included, It is the policy of the facility to follow the orders of the physician . 4) All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received. The deficient practice was corrected on June 25, 2025 after the facility implemented a systemic plan that included the following actions: Ad HOC QAPI meeting was held on June 25, 2025 an action plan included inservice review of policy for physicians orders and other documentation in the residents records with staff, and the on going monitoring of the transcribing physicians orders and documentation.This citation relates to Complaint 2561130.3.1-25(a)