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	05/13/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's lab and vital signs were monitored following an increase in medication (digoxin) dosage per physician orders and the resident's plan of care that resulted in a hospitalization for 1 of 3 residents reviewed for hospitalizations (Resident D). Resident D was admitted to the hospital with a diagnosis of digoxin poisoning and life-threatening hyperkalemia (elevated potassium).Finding includes:Record review on 5/12/26 at 12:30 P.M., indicated Resident D's diagnoses included, but were not limited to, heart failure, atrial fibrillation (A-fib) and atrial flutter, hypokalemia, and hypertension. The most recent quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated the resident had moderate cognitive impairment. Physician orders included, but were not limited to: digoxin 125 micrograms (mcg) for atrial fibrillation (started 1/8/26 and discontinued 2/13/26), repeat digoxin level in two weeks 2/27/26 (ordered 2/13/26), digoxin 250 mcg for increased heart rate (started 2/14/26 and discontinued 4/27/26), and clonidine hydrochloride (HCl) 0.2 milligrams (mg) as needed for systolic blood pressure greater than 180 mm Hg (millimeters of mercury) (started 4/27/26).The care plan included, but was not limited to, resident has chronic A-fib with interventions - labs per order and medications per order (started 2/9/26), at risk for cerebrovascular accident (CVA) with an intervention of monitor labs as ordered (started 2/9/26), and at risk for increased blood pressure with an intervention to monitor blood pressure per physician order and facility policy (started 2/9/26). The Medication Administration Record (MAR) for the month of February 2026 included digoxin 125 mcg was administered daily until it was discontinued on 2/13/26. Resident D's heart rate was monitored and documented with each administration up until 2/13/26. On 2/14/26, digoxin 250 mcg was started and continued to be administered daily through February, March, and April with no documented heart rate monitoring with administration.Labs indicated the resident's most recent digoxin level was completed on 2/13/26. No digoxin level was obtained on 2/27/26 per the physician's order. Resident D's ordered digoxin level lab for 2/27/26 was not documented as completed. The MAR for the months of April and May 2026 indicated the as needed order for clonidine HCl 0.2 mg for systolic blood pressure greater than 180 mm Hg was never administered and since the new order was obtained from the hospital on 4/27/26, the resident's blood pressure had only been documented on two occasions. Documented vital signs from February 14, 2026, through May 2026 included the following heart rate and blood pressure monitoring: 2/17/26 - 98 beats per minute (bpm), 142/100 (systolic/diastolic) mm Hg 3/4/26 - 100 bpm, 140/88 mm Hg4/1/26 - 67 bpm, (no blood pressure)4/24/26 - 41 bpm, 145/64 mm Hg4/27/26 - 78 bpm, 130/84 mm Hg4/28/26 - 61 bpm, 109/70 mm HgNurse's progress notes included, but were not limited to:2/17/26 9:16 A.M. - Resident was readmitted to facility following hospitalization due to COVID-19 and atrial fibrillation with rapid ventricular response.4/24/26 12:30 P.M. - Resident was propelling herself to the dining room and began having trouble with locomotion. Resident was assisted by staff to the dining room where she continued to decline. Heart rate was 38-43 beats per minute. Resident was unable to Perform baseline activities of daily living. Resident was unsure of where she was. Resident was unable to feed self per her normal, Emergency Medical Service (EMS) arrived, and report was called to the emergency room. 4/24/26 at 6:50 P.M. - Resident (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	admitted to intensive care unit with digoxin toxicity, hyperkalemia, and acute kidney injury. 5/12/26 at 9:12 A.M. - (Physician Provider Note) Resident was recently referred to therapy due to having an overall decline in her functional abilities that include decreased functional mobility, decreased transfers, reduced ability to ambulate safely, increased need for assistance, and reduced activities of daily living participation. Hospital records included emergency department provider notes, dated 4/24/26 at 1:02 P.M., that indicated the resident's blood pressure was 168/70 mm Hg and the resident's heart rate was 33 bpm. Lab values included a digoxin level of 2.39 nanograms/milliliter (ng/mL) (therapeutic range is 0.7 - 2.0 ng/mL), and potassium level of 9.4 milliequivalents/liter (mEq/L) (normal level is between 3.5 - 5.2 mEq/L). The emergency department assessment and plan included digoxin toxicity: concern for chronic overdose with suspected acute kidney injury (AKI). The emergency department course of treatment included, dialysis line placed. Patient to have potassium dialyzed as needed. STAT (immediate) potassium will be repeated after central line placement. Resident to be admitted to intensive care unit with diagnosis of digoxin poisoning. The hospital history and physical note dated 4/24/26 at 3:25 P.M., included that Resident D was admitted to the intensive care unit for life-threatening hyperkalemia.The hospital discharge summary note, dated 4/27/26 at 3:23 P.M., included Resident D's medications were modified significantly. Resident to start clonidine 0.2 mg two times daily as needed for systolic blood pressure greater than 180 mm Hg.During an interview on 5/12/26 at 1:55 P.M., the director of nursing (DON) indicated a resident's heart rate should be monitored prior to every administration of digoxin. During an interview on 5/13/26 at 12:10 P.M., RN 4 indicated Resident D's vital signs should be obtained at every medication pass, but that staff did not document every time vital signs were obtained. During an interview on 5/13/26 at 10:10 A.M., RN 6 indicated the facility did not have a policy regarding when vital signs should be obtained and indicated the facility would follow the physicians' orders.During a review of a facility training related to digoxin toxicity, an undated facility policy titled Lab Scheduling/Tracking. The policy included, Policy: It is the policy of the facility to ensure that laboratory tests ordered by the physician are systematically scheduled and tracked so that ordered lab work is obtained and results are received and reported timely.According to nursestudy.net, nursing considerations for the medication digoxin included, Assess vital signs, especially heart rate and rhythm. The apical pulse must be taken for a full minute before administration. Monitor serum digoxin levels (therapeutic range: 0.8-2.0 ng/mL) .This citation relates to intake 2975665.410 IAC (Indiana Administrative Code)16.2.3.1-37(a)