

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Waters of Covington, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E Liberty St Covington, IN 47932	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interview, the facility failed to ensure a resident's family member was notified in a timely manner of a resident's fracture for 1 of 4 residents reviewed for accidents (Resident B). Findings include: Resident B's record was reviewed on 7/22/25 at 11:23 a.m. Diagnoses on the resident's profile included, but were not limited to, cerebral palsy (a group of neurological disorders that affect movement, muscle tone, and posture) and unspecified fracture of the upper end of the right tibia. A significant change Minimum Data Set (MDS) assessment, dated 7/1/25, indicated the resident had a severe cognitive impairment, was dependent for chair/bed transfers, and had one fall with a major injury since the prior assessment. A progress note, dated 6/18/25 at 12:00 p.m., indicated it was a late entry. The note indicated the Certified Nurse Aide (CNA) notified the nurse the resident slid out of the mechanical lift. The resident was found lying on the floor on her right side, and there were two CNAs in the room. The CNAs reported the resident slid out of the mechanical lift sling and landed on her right side when the resident began moving during the transfer. One CNA reported she was able to prevent the resident from hitting her head. The resident was assessed and did not complain of pain. The Nurse Practitioner (NP) was in the facility and assessed the resident. The NP stated the resident could be moved to the bed, and the resident was assisted back to bed. The resident's family member was notified of the incident. The resident requested to get up for lunch, and the NP said the resident was able to get out of bed. The resident was assisted out of bed and went to lunch. A progress note, dated 6/19/25 at 4:31 a.m., indicated x-rays were ordered for the resident's right shoulder and right knee. A progress note, dated 6/19/25 at 4:44 a.m., indicated the mobile x-ray company was scheduled to complete the x-rays in the morning. A progress note, dated 6/19/25 at 11:45 a.m., indicated the mobile x-ray company completed the x-rays of the resident's right shoulder and right knee. An x-ray report, dated 6/19/25, indicated the resident had a right tibia fracture. The physician signed the report and indicated, apply splint refer to ortho [orthopedics]. A progress note, dated 6/19/25 at 12:29 p.m., indicated the resident's x-ray results were received, and there was a fracture to the right tibia. The physician was notified and ordered a splint and orthopedic referral. The orthopedic office was contacted to schedule an appointment. The note lacked documentation the resident's family member was notified. A progress note, dated 6/20/25 at 10:30 a.m., indicated the resident's Power of Attorney (POA) was notified of the resident's right tibia fracture. The record lacked documentation the resident's POA was notified prior to this date and time. During an interview, on 7/23/25 at 9:20 a.m., the Director of Nursing (DON) indicated she noticed in the morning meeting, on 6/20/25, Resident B's family member had not been notified of the resident's fracture. They followed up with the staff nurse and verified the family member had not been notified, and the staff nurse indicated she had not notified the family. Once they found the notification was not completed, the DON notified the resident's family member. The resident's family member should have been notified of the new fracture on the same day it was found. On 7/23/25 at 11:09 a.m., the DON provided a document titled, Change in a Resident's Condition or Status, last revised in February 2021, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Statement: Our facility notifies the resident representative of changes in the resident's medical.condition.Policy Interpretation and Implementation.4.a nurse will notify the resident's representative when: a. the resident is involved in any accident or incident that results in an injury.b. there is a significant change in the resident's physical.status. This citation relates to Complaint 1380602. 3.1-5(a)(2)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure a resident was assessed for and safely transferred in a mechanical lift resulting in actual harm when the resident fell from the mechanical lift sling during a transfer and sustained a fracture to the right tibia (bone in the lower leg) (Resident B), failed to ensure residents were appropriately transferred in mechanical lifts using the correct slings (Residents B and D), and to ensure a resident with multiple falls received updated interventions to prevent further falls (Resident C) for 3 of 4 residents reviewed for accidents. Findings include: 1. Resident B's record was reviewed on 7/22/25 at 11:23 a.m.</p> <p>Diagnoses on the resident's profile included, but were not limited to, cerebral palsy (a group of neurological disorders that affect movement, muscle tone, and posture) and unspecified fracture of the upper end of the right tibia.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 7/1/25, indicated the resident had a severe cognitive impairment, was dependent for chair/bed transfers, and had one fall with a major injury since the prior assessment.</p> <p>A physician's order, dated 8/29/19, indicated the resident was transferred with a mechanical lift.</p> <p>A care plan, initiated on 8/29/19, indicated the resident required staff assistance with activities of daily living (ADLs) related to cerebral palsy. Interventions included, but were not limited to, encourage the use of assistive devices as needed, mechanical lift.</p> <p>Current physician's orders lacked documentation of orders related to the resident's right tibia fracture.</p> <p>A fall risk review, dated 6/18/25, indicated the resident was a high risk for falls.</p> <p>A progress note, dated 6/18/25 at 12:00 p.m., indicated it was a late entry. The note indicated the Certified Nurse Aide (CNA) notified the nurse the resident slid out of the mechanical lift. The resident was found lying on the floor on her right side, and there were two CNAs in the room. The CNAs reported the resident slid out of the mechanical lift sling and landed on her right side when the resident began moving during the transfer. One CNA reported she was able to prevent the resident from hitting her head. The resident was assessed and did not complain of pain. The Nurse Practitioner (NP) was in the facility and assessed the resident. The NP stated the resident could be moved to the bed, and the resident was assisted back to bed. The resident's family member was notified of the incident. The resident requested to get up for lunch, and the NP said the resident was able to get out of bed. The resident was assisted out of bed and went to lunch.</p> <p>A progress note, dated 6/18/25 at 1:10 p.m., indicated the resident fell out of the Hoyer sling, at 11:45 a.m., during a transfer from the bed to the chair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A Situation, Background, Assessment, Recommendation (SBAR) form, dated 6/18/25 at 11:45 a.m., indicated the resident had a fall, and the recommendation was to monitor the patient and use a bigger Hoyer (mechanical lift) sling when transferring.</p> <p>A progress note, dated 6/19/25 at 4:31 a.m., indicated x-rays were ordered for the resident's right shoulder and right knee.</p> <p>A progress note, dated 6/19/25 at 4:44 a.m., indicated the mobile x-ray company was scheduled to complete the x-rays in the morning.</p> <p>An Interdisciplinary Team (IDT) progress note, dated 6/19/25 at 10:12 a.m., indicated the IDT was reviewing the resident's fall from 6/8/25 [sic]. The resident slipped out of the mechanical lift sling while being transferred. The root cause was "slid out of Hoyer lift." The intervention was to ensure the appropriate sling was being used. The IDT consisted of the Dietary Manager, MDS Coordinator, Social Services Director (SSD), and Assistant Director of Nursing (ADON).</p> <p>The medical record lacked documentation of an assessment of the resident for the safe use of the mechanical lift was completed.</p> <p>The incident investigation file contained the following two undated witness statements.</p> <p>A witness statement from CNA 4 stated, "I was in [Resident B's] room providing care for her; put the Hoyer lift sling under her. [CNA 5] entered the room. We put the sling on the Hoyer lift. As I was pulling out from the bed as I was turning the Hoyer, [Resident B] began to move/wiggle in the sling. I asked her to stop moving. [CNA 5] and I were able to catch her head to prevent it from hitting the floor";</p> <p>A witness statement from CNA 5 stated, "I went into [Resident B's] room to help [CNA 4] transfer her with the Hoyer lift. We put the sling on the Hoyer lift. As [CNA 4] was pulling the Hoyer from out from the bed and turning it, [Resident B] began to move/wiggle in the sling. [CNA 4] asked her to stop moving. I moved closer to help with the transfer, [Resident B] arched her back and slid out of the Hoyer sling. Although we did not keep her from falling, we were able to catch her head to prevent her from hitting her head";</p> <p>A progress note, dated 6/19/25 at 11:45 a.m., indicated the mobile x-ray company completed the x-rays of the resident's right shoulder and right knee.</p> <p>An x-ray report, dated 6/19/25, indicated the resident had a right tibia fracture. The physician signed the report and indicated, "apply splint refer to ortho [orthopedics]";</p> <p>A progress note, dated 6/19/25 at 12:29 p.m., indicated the resident's x-ray results were received, and there was a fracture to the right tibia. The physician was notified and ordered a splint and orthopedic referral. The orthopedic office was contacted to schedule an appointment.</p> <p>A physician's order, dated 6/20/25, indicated the resident was able to get in the wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A care plan, initiated on 6/20/25, indicated the resident had a fracture to the right tibia from a fall on 6/18/25. Interventions included, but were not limited to, handle gently when moving or positioning and maintain body alignment.</p> <p>An IDT progress note, dated 6/24/25 at 4:43 p.m., indicated it was an IDT fall follow up clarification. Upon chart review, there was a clarification on the date and events. The fall occurred on 6/18/25, and the IDT note, dated 6/19/25, mistakenly indicated it occurred on 6/8/25. The resident was being transferred via mechanical lift by two CNAs, became restless, and positioned her body in a straight board position. This position caused her to "maneuver herself out of the Hoyer lift sling." The resident fell approximately three feet, and the CNAs were able to prevent her head from hitting the floor. The resident landed on her right leg. The NP was in the facility, assessed the resident, and indicated she was able to be moved from the floor to the bed. The resident was assessed and was not in pain. The root cause of the incident was the resident became restless and maneuvered herself out of the sling. Interventions included immediate assessment by the NP, staff education for mechanical lift transfers and dealing with residents who had increased agitation during a mechanical lift transfer, x-ray completed, orthopedic consult completed with a new order for a follow-up x-ray in six weeks.</p> <p>An orthopedic physician progress note, dated 6/24/25, stated, "Given that the patient is nonambulatory, I strongly recommend nonoperative management, and the patient and her family concurred. Supportive care will be provided, including placing support underneath the leg during lifting and transferring. A knee immobilizer or brace is not recommended, as it may lead to increased swelling and complications. The fracture is expected to heal in approximately three to four months.".</p> <p>A progress note, dated 6/25/25 at 2:05 a.m., indicated the resident was seen by the orthopedic physician on 6/24/25, but the nurse had not seen any paperwork from the appointment.</p> <p>During an interview, on 7/22/25 at 1:42 p.m., Resident B indicated she fell out of the mechanical lift because the staff did not have her in the lift "right." When she fell, her leg hurt.</p> <p>During an interview, on 7/22/25 at 2:41 p.m., Qualified Medication Aide (QMA) 7 indicated she worked 6/18/24 when the resident fell out of the mechanical lift sling. Someone reported to her the resident fell, and she went to get the ADON. The staff stated the resident "bucked" and fell out of the sling. She was not sure if that was unusual for the resident because she did not normally provide direct resident care. After the incident, the staff received training regarding mechanical lift transfers but not regarding sling size. If a resident needed a mechanical lift sling, staff retrieved it from the supply. The size should have been determined by weight. She thought the resident's height might have been a factor in the mechanical lift sling size as well, but she was not sure about hip size.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 7/22/25 at 2:47 p.m., CNA 8 indicated she was familiar with Resident B. There had been issues transferring the resident with the mechanical lift because of her contractures and stiffness. The facility got a new mechanical lift sling for her, and it helped. The new sling crosses between the resident's legs. The sling they were using before was a "bath sling." It was a large rectangle that acted like a hammock and seemed too big. She indicated the staff was not trained on which type of mechanical lift sling to use or which size. There have been times when staff used bath slings when they were not really appropriate because they were not sure what to use or the correct equipment was not available.</p> <p>During an interview, on 7/22/25 at 3:01 p.m., the Administrator indicated they purchased personalized mechanical lift slings for each resident who used the lift based on their weights. They wrote the resident's name on the label. At the same time, the bath sling was observed and was noted to be a large rectangle shape. The sling was not a [mechanical lift brand name] sling.</p> <p>During an observation, on 7/23/25 at 9:50 a.m., CNA 4 and CNA 9 transferred Resident B from the bed to the chair with the mechanical lift. The legs of the lift were closed and under the bed. The CNAs attached the sling loops to the mechanical lift. CNA 4 lifted Resident B up and off the bed, moved the mechanical lift backwards, turned to the right, and positioned it in front of the resident's wheelchair. Once the mechanical faced the resident's wheelchair, CNA 4 opened the legs of the mechanical lift and pushed it towards the resident's wheelchair. CNA 9 guided the resident into the wheelchair as CNA 4 lowered the lift. During the transfer, the straps of the mechanical lift pad were crossed between the resident's legs, but the resident's buttocks protruded through the opening of the mechanical lift sling and her legs hung over the sling straps at her knees. The CNAs did not support the resident's fractured leg during the transfer. At the same time, the ADON indicated the resident's buttocks were positioned that way due to her contractures. The mechanical lift sling was observed to have the resident's name on it and was a different brand than the mechanical lift. The CNAs were unable to verbalize what size sling the resident required.</p> <p>On 7/23/25 at 10:27 a.m., the Housekeeping Supervisor provided a document titled, "Hoyer," and indicated it was a list of residents and their weights provided to her by nursing. When she was provided with this list, she was told to order each resident on it a new mechanical lift sling based on their weight. She was not told to use any other body measurements, such as height or hip width, to determine sling size. Prior to the new slings being ordered, staff used full-body, rectangular slings for the mechanical lift for all residents. The new slings ordered were a different shape and the straps crossed between the resident's legs. She was approved to order one new sling for the residents who required a mechanical lift for transfers and was supposed to order a second sling for each resident later. If the new sling was soiled, she had one extra of the new style sling, but only one size. Otherwise, the staff would have needed to use the old rectangular style slings they used before until the new sling was laundered. She ordered the slings through the medical supply company she always used and was not told they needed to be [mechanical lift brand name] slings.</p> <p>During an interview, on 7/23/25 at 10:50 a.m., CNA 4 indicated she was not notified of any requirement to do anything with Resident B's fractured leg during transfers. She was not aware the resident's fractured leg needed support during transfers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 7/23/25 at 1:22 p.m., CNA 4 and CNA 5 indicated they were the CNAs who transferred Resident B when she fell out of the mechanical lift sling. They used the rectangular lift sling. The resident stiffened up and fell out of the mechanical lift sling. They had new mechanical lift slings that crossed between the residents's legs, and they worked better.</p> <p>On 7/23/25 at 1:40 p.m., the DON provided a document titled, "Interdisciplinary Resident Screen," dated 6/19/25, and indicated it was the mechanical lift assessment for Resident B. The document indicated the resident had a recent fall and received a screening for physical therapy. The document did not include an assessment of the resident's appropriateness or safety for use of the mechanical lift and was not a mechanical lift assessment. At the same time, the DON indicated she was not able to find any other mechanical lift assessments for the resident.</p> <p>On 7/22/25 at 2:55 p.m., the Administrator provided the user manual for the mechanical lift used by the facility, dated 10/1/18. The user manual indicated, "Use common sense in all lifts. Special care MUST BE taken with people with disabilities who cannot cooperate while being lifted. [Mechanical lift brand name] slings and patient lift accessories are specifically designed to be used in conjunction with the [mechanical lift brand name] patient lifts. Slings and accessories designed by other manufacturers are not to be utilized as a component of [mechanical lift brand name] patient lift system. Using the sling; WARNING; If the patient is in a wheelchair, secure the wheel locks in place to prevent the chair from moving forwards or backwards; When using an adjustable lift base lift, the legs MUST be in the maximum opened/locked position before lifting the patient; The legs of the lift must be in the maximum open position for optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the lift under a bed, close the legs of the lift only as long as it takes to position the lift over the patient and lift the patient off the surface of the bed. When the legs of the lift are no longer under the bed, return the legs of the lift to the maximum open position and lock the shifter handle immediately;."</p> <p>On 7/23/25 at 11:18 a.m., the DON provided a document titled, "Guidelines for Mechanical Lift Transfer/Usage," dated 7/8/24, and indicated it was the policy currently being used by the facility. The policy indicated, "Getting ready to use a Mechanical Lift; 7) Never use a mechanical lift on a resident who is agitated, resistant or combative; 10) Make sure that you have the correct sling for the resident. The sling needs to be: a) Compatible with the specific mechanical lift being used b) Correct size for the resident-this is determined using the resident's size, weight, and hip measurements in accordance with the manufacturer's recommendations;."</p> <p>2. On 7/22/25 at 1:00 p.m., the medical record of Resident D was reviewed. The resident's most recent admission to the facility was on 10/25/24. Admitting diagnosis included but not limited to repeated falls and reduced mobility.</p> <p>Review of physician orders indicated the record lacked an order to use the mechanical lift for transfers.</p> <p>A quarterly Minimum Data Assessment (MDS), dated [DATE], indicated the resident was extensive assist with two persons for transfers and was cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A care plan, dated 4/12/24, indicated the resident was at risk for falls. Interventions included, but were not limited to, antiroll back in wheelchair.</p> <p>A care plan, dated 8/1/24, indicated resident required assistance with activity of daily living care needs. Interventions included, but were not limited to, staff assist with transfers as needed, and assess by therapy as needed.</p> <p>The care plan lacked documentation of use of mechanical lift to transfer.</p> <p>On 7/22/25 at 1:50 p.m., observed Resident D being transferred from wheelchair to bed. Observed Certified Nurse aide (CNA) 4 operating the mechanical lift and CNA 9 assisting to position the resident in the mechanical lift pad. The top back of the pad observed to be approximately 4 inches above the back of the resident's head.</p> <p>The resident was lifted approximately 18 inches over the wheelchair arm rest and moved to the bed. CNA 9 failed to lock the wheelchair prior to lifting the resident from the chair. CNA 4 failed to lock the brakes on the mechanical lift prior to lowering the resident onto the bed.</p> <p>3. On 7/22/25 at 2:00 p.m., the medical record of Resident C was reviewed. The most recent admission to the facility was on 10/4/24. Admitting diagnosis included, but not limited to, chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), weakness, and falls.</p> <p>A care plan, dated 3/29/24, indicated the resident was at risk for falls. Interventions included, but not limited to, anti rollbacks to wheelchair dated 1/24/23, color call light dated 4/4/22, and fall mat while in bed dated 9/6/23.</p> <p>The record indicated the resident had fallen on the following dates. On 6/22/25 the resident fell out of the wheelchair. On 6/28/25 the resident fell on the floor in front of her wheelchair. On 7/11/25 the resident fell out of wheelchair in the hall. On 7/14/25 the resident fell out of bed onto a mat. On 7/18/25 the resident was found sitting on the floor in the hallway in front of the wheelchair.</p> <p>The medical record lacked documentation of new preventive interventions being implemented after each fall.</p> <p>A fall risk assessment, dated 6/28/25, indicated the fall risk score was 13 and the resident was a high fall risk.</p> <p>A quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated the resident was cognitively impaired.</p> <p>A fall risk assessment, dated 7/19/25, indicated the fall risk score was 17 and the resident continued to be high fall risk.</p> <p>On 7/23/25 at 11:13 a.m., during an interview the Director of Nurses (DON) indicated the care plans were updated after incidents during the IDT (inter disciplinary team) meeting. The DON indicated the MDS Coordinator would update the care plan with interventions at that time.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of four employee files hired between 2/7/24 and 7/31/24 lacked documentation of competency skills evaluations for use of mechanical lifts.</p> <p>On 7/23/25 at 11:42 a.m., observed Resident C laying on her back across the bed sleeping. Observed the wheelchair in front of the resident. Call light had red tape on the light, the wheelchair had anti tip bar on the back, there was not a mat on the floor next to the bed.</p> <p>On 7/22/2025 at 2:55 p.m., the provided a document titled, "Guidelines for incidents, accidents, falls, " dated 6/30/23, and indicated it was the policy currently being used by the facility. The policy indicated, ".11. Each fall needs a new care plan intervention rolled out&hellip;15. Based on the results of the incident, accident, fall, the resident's care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place&hellip;.&rdquo;</p> <p>This citation relates to Complaint 1380602.</p> <p>3.1-45(a)</p>		

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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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff were competent in performing mechanical lift transfers during 2 of 2 observed mechanical lift transfers (Residents B and D). This deficient practice had the potential to affect 15 of 15 residents who required a mechanical lift for transfers. Findings include: 1. Resident B's record was reviewed on 7/22/25 at 11:23 a.m. Diagnoses on the resident's profile included, but were not limited to, cerebral palsy (a group of neurological disorders that affect movement, muscle tone, and posture) and unspecified fracture of the upper end of the right tibia.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 7/1/25, indicated the resident had a severe cognitive impairment, was dependent for chair/bed transfers, and had one fall with a major injury since the prior assessment.</p> <p>A physician's order, dated 8/29/19, indicated the resident was transferred with a mechanical lift.</p> <p>A progress note, dated 6/18/25 at 12:00 p.m., indicated it was a late entry. The note indicated the Certified Nurse Aide (CNA) notified the nurse the resident slid out of the mechanical lift. The resident was found lying on the floor on her right side, and there were two CNAs in the room. The CNAs reported the resident slid out of the mechanical lift sling and landed on her right side when the resident began moving during the transfer.</p> <p>A progress note, dated 6/19/25 at 4:31 a.m., indicated x-rays were ordered for the resident's right shoulder and right knee.</p> <p>An interdisciplinary team (IDT) progress note, dated 6/19/25 at 10:12 a.m., indicated the IDT was reviewing the resident's fall from 6/8/25 [sic]. The resident slipped out of the mechanical lift sling while being transferred. The root cause was "slid out of Hoyer lift." The intervention was to ensure the appropriate sling was being used. The IDT consisted of the Dietary Manager, MDS Coordinator, Social Services Director (SSD), and Assistant Director of Nursing (ADON).</p> <p>An x-ray report, dated 6/19/25, indicated the resident had a right tibia fracture. The physician signed the report and indicated, "apply splint refer to ortho [orthopedics]."</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An IDT progress note, dated 6/24/25 at 4:43 p.m., indicated it was an IDT fall follow up clarification. Upon chart review, there was a clarification on the date and events. The fall occurred on 6/18/25, and the IDT note, dated 6/19/25, mistakenly indicated it occurred on 6/8/25. The resident was being transferred via mechanical lift by two CNAs, became restless, and positioned her body in a straight board position. This position caused her to &ldquo;maneuver herself out of the Hoyer lift sling.&rdquo; The resident fell approximately three feet, and the CNAs were able to prevent her head from hitting the floor. The resident landed on her right leg. The NP was in the facility, assessed the resident, and indicated she was able to be moved from the floor to the bed. The resident was assessed and was not in pain. The root cause of the incident was the resident became restless and maneuvered herself out of the sling. Interventions included immediate assessment by the NP, staff education for mechanical lift transfers and dealing with residents who had increased agitation during a mechanical lift transfer, x-ray completed, orthopedic consult completed with a new order for a follow-up x-ray in six weeks.</p> <p>An orthopedic physician progress note, dated 6/24/25, stated, &ldquo;&hellip;Given that the patient is nonambulatory, I strongly recommend nonoperative management, and the patient and her family concurred. Supportive care will be provided, including placing support underneath the leg during lifting and transferring. A knee immobilizer or brace is not recommended, as it may lead to increased swelling and complications&hellip;The fracture is expected to heal in approximately three to four months&hellip;.&rdquo;</p> <p>The incident investigation file contained the following two undated witness statements.</p> <p>A witness statement from CNA 4 stated, &ldquo;I was in [Resident B&rsquo;s] room providing care for her&hellip;put the Hoyer lift sling under her. [CNA 5] entered the room. We put the sling on the Hoyer lift. As I was pulling out from the bed as I was turning the Hoyer, [Resident B] began to move/wiggle in the sling. I asked her to stop moving. [CNA 5] and I were able to catch her head to prevent it from hitting the floor&hellip;&rdquo;</p> <p>A witness statement from CNA 5 stated, &ldquo;I&hellip;went into [Resident B&rsquo;s] room to help [CNA 4] transfer her with the Hoyer lift. We put the sling on the Hoyer lift. As [CNA 4] was pulling the Hoyer from out from the bed and turning it, [Resident B] began to move/wiggle in the sling. [CNA 4] asked her to stop moving. I moved closer to help with the transfer, [Resident B] arched her back and slid out of the Hoyer sling. Although we did not keep her from falling, we were able to catch her head to prevent her from hitting her head&hellip;.&rdquo;</p> <p>During an interview, on 7/22/25 at 2:41 p.m., Qualified Medication Aide (QMA) 7 indicated she worked 6/18/24 when the resident fell out of the mechanical lift sling. Someone reported to her the resident fell, and she went to get the ADON. The staff stated the resident &ldquo;bucked&rdquo; and fell out of the sling. She was not sure if that was unusual for the resident because she did not normally provide direct resident care. After the incident, the staff received training regarding mechanical lift transfers but not regarding sling size. If a resident needed a mechanical lift sling, staff retrieved it from the supply. The size should have been determined by weight. She thought the resident&rsquo;s height might have been a factor in the mechanical lift sling size as well, but she was not sure about hip size.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview, on 7/22/25 at 2:47 p.m., CNA 8 indicated she was familiar with Resident B. There had been issues transferring the resident with the mechanical lift because of her contractures and stiffness. The facility got a new mechanical lift sling for her, and it helped. The new sling crossed between the resident's legs. The sling they were using before was a "bath sling." It was a large rectangle that acted like a hammock and seemed too big. She indicated the staff was not trained on which type of mechanical lift sling to use or which size. There had been times when staff used bath slings when they were not really appropriate because they were not sure what to use or the correct equipment was not available.</p> <p>During an observation, on 7/23/25 at 9:50 a.m., CNA 4 and CNA 9 transferred Resident B from the bed to the chair with the mechanical lift. The legs of the lift were closed and under the bed. The CNAs attached the sling loops to the mechanical lift. CNA 4 lifted Resident B up and off the bed, moved the mechanical lift backwards, turned to the right, and positioned it in front of the resident's wheelchair. Once the mechanical faced the resident's wheelchair, CNA 4 opened the legs of the mechanical lift and pushed it towards the resident's wheelchair. CNA 9 guided the resident into the wheelchair as CNA 4 lowered the lift. During the transfer, the straps of the mechanical lift pad were crossed between the resident's legs, but the resident's buttocks protruded through the opening of the mechanical lift sling and her legs hung over the sling straps at her knees. The CNAs did not support the resident's fractured leg during the transfer. At the same time, the ADON indicated the resident's buttocks were positioned that way due to her contractures. The mechanical lift sling was observed to have the resident's name on it and was a different brand than the mechanical lift. The CNAs were unable to verbalize what size sling the resident required.</p> <p>During an interview, on 7/23/25 at 10:50 a.m., CNA 4 indicated she was not notified of any requirement to do anything with Resident B's fractured leg during transfers. She was not aware the resident's fractured leg needed support during transfers.</p> <p>During an interview, on 7/23/25 at 1:22 p.m., CNA 4 and CNA 5 indicated they were the CNAs who transferred Resident B when she fell out of the mechanical lift sling. They used the rectangular lift sling. The resident stiffened up and fell out of the mechanical lift sling. They had new mechanical lift slings that crossed between the residents' legs, and they worked better.</p> <p>On 7/22/25 at 2:55 p.m., the Administrator provided the user manual for the mechanical lift used by the facility, dated 10/1/18. The user manual indicated, "Use common sense in all lifts. Special care MUST BE taken with people with disabilities who cannot cooperate while being lifted. [Mechanical lift brand name] slings and patient lift accessories are specifically designed to be used in conjunction with the [mechanical lift brand name] patient lifts. Slings and accessories designed by other manufacturers are not to be utilized as a component of [mechanical lift brand name] patient lift system. Using the sling; WARNING; If the patient is in a wheelchair, secure the wheel locks in place to prevent the chair from moving forwards or backwards; When using an adjustable lift base lift, the legs MUST be in the maximum opened/locked position before lifting the patient; The legs of the lift must be in the maximum open position for optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the lift under a bed, close the legs of the lift only as long as it takes to position the lift over the patient and lift the patient off the surface of the bed. When the legs of the lift are no longer under the bed, return the legs of the lift to the maximum open position and lock the shifter handle immediately;."</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/23/25 at 11:18 a.m., the DON provided a document titled, "Guidelines for Mechanical Lift Transfer/Usage," dated 7/8/24, and indicated it was the policy currently being used by the facility. The policy indicated, "Getting ready to use a Mechanical Lift;7) Never use a mechanical lift on a resident who is agitated, resistant or combative;10) Make sure that you have the correct sling for the resident. The sling needs to be: a) Compatible with the specific mechanical lift being used b) Correct size for the resident-this is determined using the resident's size, weight, and hip measurements in accordance with the manufacturer's recommendations;"</p> <p>2. On 7/22/25 at 1:50 p.m., observed Resident D being transferred from wheelchair to bed. Observed Certified Nurse aide (CNA) 4 operating the mechanical lift and CNA 9 assisting to position the resident in the mechanical lift pad. The top back of the pad observed to be approximately 4 inches above the back of the residents head.</p> <p>CNA 4 asked the resident not to hold onto the bar and instructed her to move her arms back and downward. When the resident pulled her arms back, both arms were moved down between the bar and the lift pad. The resident was lifted approximately 18 inches over the wheelchair arm rest and moved to the bed.</p> <p>CNA 9 failed to lock the wheelchair prior to lifting the resident from the chair. CNA 4 failed to lock the brakes on the mechanical lift prior to lowering the resident onto the bed.</p> <p>On 7/23/25 at 9:45 a.m., during a random observation, observed Resident (E) sitting in wheelchair in the main dining room. The resident was sitting on a mechanical lift sling. Observation of the label indicated the residents name was not on the label.</p> <p>On 7/23/25 at 10:00 a.m., during a random observation noted 2 mechanical lift slings were labeled with the residents names and dated 7/9/25.</p> <p>On 7/22/25 at 2:10 p.m., during interview CNA 4 indicated she did not know how to determine the correct size of the lift pad to be used for the resident. She indicated she thought the lift pad was the correct size to be used for the resident. She acknowledged she should have locked the wheelchair prior to lifting the resident from the wheelchair.</p> <p>On 7/22/25 at 2:20 p.m., during interview Qualified Medication Aide (QMA) 6 indicated she did not know how to determine the correct side of a mechanical lift pad to be used for a resident and she would determine the size by looking at the resident and if the lift pad was higher over the back of the residents head the pad would be too big. She indicated when she was transferring a resident from a wheelchair she would raise the bed to be even with the edge of the wheelchair arm rest and would raise the resident up just enough to clear the arm rest on the wheelchair.</p> <p>On 7/23/25 at 1:22 p.m. during interview CNA 4 and CNA 5 indicated they transferred the resident the way they did today during the observation except the resident moves a lot and stiffens up. They were using the rectangular lift pads. CNA 5 indicated she doesn't normally work that hall, so she hasn't had any training specific to how to transfer based on the residents risk factors. When they were hired/before the incident they demonstrated how to use the lift properly. After the incident, they had to re-do the mechanical lift competencies and the Assistant Director of Nursing (ADON) observed them do it to make sure they were able to do it.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/23/25 at 1:22 p.m. during interview CNA 4 and CNA 5 indicated they transferred the resident the way they did during the observation except the resident moved a lot and stiffens up. They were using the rectangular lift pads. CNA 5 indicated she didn't normally work that hall, so she had not had any training specific to how to transfer based on the resident risk factors. When they were hired /before the incident they demonstrated how to use the lift properly. They felt like they were provided with equipment, staffing, etc. that they needed to take care of the residents. All residents had their own Hoyer lift pads with their names on them. If the pad needed laundered they put it in the laundry and then got a different pad. They usually got back pretty quickly. They would use the rectangle one right now until the other one came back until the second set of resident specific ones came in.</p> <p>On 7/22/25 at 2:47 p.m. during interview CNA 8 indicated she was not sure everyone was trained on which Hoyer slings to use or what size should be used per sling. There had been times where people had used "bath slings" even when that was not really appropriate either because they didn't know what to use or because they didn't have the correct thing available.</p> <p>On 7/22/25 at 2:30 p.m., the medical record of Resident D was reviewed. The residents most recent admission to the facility was on 10/25/24. The record lacked documentation of a physician order to use a mechanical lift for transfers.</p> <p>A quarterly Minimum Data Assessment (MDS) dated [DATE] indicated he resident was extensive assist with two persons for transfers and was cognitively impaired. The residents weight was obtained on 7/8/25 and recorded as 127 lb. According to the manufacture guidelines the residents weight determined she was to use a small mechanical lift pad.</p> <p>On 7/22/2025 at 2:55 p.m., the Administrator provided a document titled, "Guidelines for Mechanical lift Transfer/Usage," dated 7/8/24, and indicated it was the policy currently being used by the facility. The policy indicated, "Getting ready to use a mechanical lift"; 3. Be sure that you have the proper mechanical lift for the resident as per the physician's order and the resident's care plan. 4. Be sure the residents weight is appropriate for the lift to be used;10;11;12;13;14;15;16;17, Position the lift and receiving surface at correct height to transfer resident easily. This can be with the bed at a higher than usual level or the waist level of the transferring staff, depending on the situation for safety and smooth transferring;18;19;20;21;22;23;24. Apply the wheel lock so it does not move once the mechanical lift is in position;25;26;27;28;29;30;31;32;33. Slowly lift the resident only as high as necessary to complete the desired transfer;34;35;36;37;38;39;40;41;42;43. Once the lift is locked and in position lower the lift;44;45;46;47;48;49;50;51;52;53;54;55;56;57;58;59;60;61;62;63;64;65;66;67;68;69;70;71;72;73;74;75;76;77;78;79;80;81;82;83;84;85;86;87;88;89;90;91;92;93;94;95;96;97;98;99;100;101;102;103;104;105;106;107;108;109;110;111;112;113;114;115;116;117;118;119;120;121;122;123;124;125;126;127;128;129;130;131;132;133;134;135;136;137;138;139;140;141;142;143;144;145;146;147;148;149;150;151;152;153;154;155;156;157;158;159;160;161;162;163;164;165;166;167;168;169;170;171;172;173;174;175;176;177;178;179;180;181;182;183;184;185;186;187;188;189;190;191;192;193;194;195;196;197;198;199;200;201;202;203;204;205;206;207;208;209;210;211;212;213;214;215;216;217;218;219;220;221;222;223;224;225;226;227;228;229;230;231;232;233;234;235;236;237;238;239;240;241;242;243;244;245;246;247;248;249;250;251;252;253;254;255;256;257;258;259;260;261;262;263;264;265;266;267;268;269;270;271;272;273;274;275;276;277;278;279;280;281;282;283;284;285;286;287;288;289;290;291;292;293;294;295;296;297;298;299;300;301;302;303;304;305;306;307;308;309;310;311;312;313;314;315;316;317;318;319;320;321;322;323;324;325;326;327;328;329;330;331;332;333;334;335;336;337;338;339;340;341;342;343;344;345;346;347;348;349;350;351;352;353;354;355;356;357;358;359;360;361;362;363;364;365;366;367;368;369;370;371;372;373;374;375;376;377;378;379;380;381;382;383;384;385;386;387;388;389;390;391;392;393;394;395;396;397;398;399;400;401;402;403;404;405;406;407;408;409;410;411;412;413;414;415;416;417;418;419;420;421;422;423;424;425;426;427;428;429;430;431;432;433;434;435;436;437;438;439;440;441;442;443;444;445;446;447;448;449;450;451;452;453;454;455;456;457;458;459;460;461;462;463;464;465;466;467;468;469;470;471;472;473;474;475;476;477;478;479;480;481;482;483;484;485;486;487;488;489;490;491;492;493;494;495;496;497;498;499;500;501;502;503;504;505;506;507;508;509;510;511;512;513;514;515;516;517;518;519;520;521;522;523;524;525;526;527;528;529;530;531;532;533;534;535;536;537;538;539;540;541;542;543;544;545;546;547;548;549;550;551;552;553;554;555;556;557;558;559;560;561;562;563;564;565;566;567;568;569;570;571;572;573;574;575;576;577;578;579;580;581;582;583;584;585;586;587;588;589;590;591;592;593;594;595;596;597;598;599;600;601;602;603;604;605;606;607;608;609;610;611;612;613;614;615;616;617;618;619;620;621;622;623;624;625;626;627;628;629;630;631;632;633;634;635;636;637;638;639;640;641;642;643;644;645;646;647;648;649;650;651;652;653;654;655;656;657;658;659;660;661;662;663;664;665;666;667;668;669;670;671;672;673;674;675;676;677;678;679;680;681;682;683;684;685;686;687;688;689;690;691;692;693;694;695;696;697;698;699;700;701;702;703;704;705;706;707;708;709;710;711;712;713;714;715;716;717;718;719;720;721;722;723;724;725;726;727;728;729;730;731;732;733;734;735;736;737;738;739;740;741;742;743;744;745;746;747;748;749;750;751;752;753;754;755;756;757;758;759;760;761;762;763;764;765;766;767;768;769;770;771;772;773;774;775;776;777;778;779;780;781;782;783;784;785;786;787;788;789;790;791;792;793;794;795;796;797;798;799;800;801;802;803;804;805;806;807;808;809;810;811;812;813;814;815;816;817;818;819;820;821;822;823;824;825;826;827;828;829;830;831;832;833;834;835;836;837;838;839;840;841;842;843;844;845;846;847;848;849;850;851;852;853;854;855;856;857;858;859;860;861;862;863;864;865;866;867;868;869;870;871;872;873;874;875;876;877;878;879;880;881;882;883;884;885;886;887;888;889;890;891;892;893;894;895;896;897;898;899;900;901;902;903;904;905;906;907;908;909;910;911;912;913;914;915;916;917;918;919;920;921;922;923;924;925;926;927;928;929;930;931;932;933;934;935;936;937;938;939;940;941;942;943;944;945;946;947;948;949;950;951;952;953;954;955;956;957;958;959;960;961;962;963;964;965;966;967;968;969;970;971;972;973;974;975;976;977;978;979;980;981;982;983;984;985;986;987;988;989;990;991;992;993;994;995;996;997;998;999;1000</p> <p>This citation relates to Complaint 1380602.</p> <p>3.1-14(i)</p>		