STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dillsboro-Ross Manor, The	12803 Lenover St Dillsboro, IN 47018

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 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 ensure staff supervised a resident that resided on a secured unit when off the unit for 1 of 3 residents reviewed for accident hazards. (Resident C) Findings include: Upon entering the facility on 06/16/25 at 4:25 P.M., on the first floor of the facility, there were no staff observed anywhere on or near the outside of the locked unit. There were three residents sitting in the dining room, outside the locked unit, including Resident C. There was an exit door approximately 10 feet to the right of where Resident C was sitting. During an observation, on 06/16/25 at 4:30 P.M., Dietary Staff 15 knocked on the dementia unit door and no staff answered the door. The door had a window that was approximately four feet by four feet and was 4.5 feet high. The dietary staff member indicated she was unsure of what the code was to get into the locked unit. The dietary staff left the area and then went upstairs to the second floor. Resident C was still sitting in the dining room outside the dementia unit with no staff present. During an observation, on 06/16/25 at 4:45 P.M., there were two visitors leaving the dementia unit when Resident C had gotten up from her chair and asked them to hold the door open to the dementia unit so she could enter. Resident C walked into the dementia unit. The clinical record for Resident C was reviewed on 06/16/25 at 5:00 P.M. A Quarterly Minimum Data Set Assessment, dated 04/30/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, Alzheimer's disease, non-Alzheimer's dementia, and diabetes. The census report indicated the resident resided on the locked dementia unit. A current open-ended physician's order, with a start date of 04/25/24, indicated the resident may reside on a secured unit. A Wandering Risk Assessment, dated 04/11/25, indicated the resident was at a moderate risk for wandering. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 06/16/25 at 5:23 P.M., Licensed Practical Nurse (LPN) 2 indicated Resident C was able to be off the locked dementia unit with staff supervision. She should have had a staff member's supervision when she was sitting outside of the locked unit. The facility could not provide a policy related to resident supervision. The current facility policy titled, Guidelines for Incidents/Accidents/Falls, was provided by the Regional Director of Plant Operations on 06/16/25 at 6:02 P.M. The policy indicated, .It is the policy of the facility to ensure that any incident/accident .is reported immediately to the nurse or appropriate person designated to be in charge . 3.1-45(a)(2)

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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. Based on record review and interview, the facility failed to provide medications in a timely manner for 1 of 3 residents reviewed for pharmacy services. (Resident B) Findings include: The clinical record for Resident B was reviewed on 6/16/25 at 5:30 P.M. A Quarterly Minimum Data Set (MDS) Assessment, dated 04/11/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, non-Alzheimer's dementia, and malnutrition. A physician's order, dated 04/16/24 through 05/29/25, indicated the staff were to administer the resident's Cyproheptadine (an antihistamine) 4 milligrams, three times a day for itching. The May 2025 Electronic Medication Administration Record indicated the resident did not receive the medication on the following dates and times due to it nor being available: From 05/19/25 through 05/23/25 for the 8:00 A.M. dose and the 2:00 P.M. dose. The clinical record lacked documentation that the physician was notified that the resident's medications were not available. During an interview, on 06/17/25 at 06/17/25 at 12:10 P.M., Licensed Practical Nurse (LPN) 2 indicated when a resident was out of a medication, she would call the pharmacy to see if they could get it out of the facility's emergency drug kit. If the medication was not available in the emergency drug kit, she would document in the EMAR that the medication was not administered due to it being unavailable, document that she spoke with the pharmacy, and let the physician know. The current facility policy titled, PHARMACY HOURS AND DELIVERY SCHEDULE, dated July 2024, was provided by the Assistant Director of Nursing (ADON) on 06/17/25 at 1:37 P.M. The policy indicated, .is open 24 hours/365 days a year. New orders and refill requests may be faxed or sent electronically at any time .0 The current, undated, facility policy titled, PHYSICIAN-ORDERS--(FOLLOWING PHYSICIAN ORDERS) was provided by the ADON on 06/17/25 at 11:35 A.M. The policy indicated, .It is the policy of the facility to follow the orders of the physician . 3.1-25(a)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on record review and interview, the facility failed to obtain a STAT x-ray in a timely manner for 1 of 3 residents reviewed for radiology services. (Resident B) Findings include: The clinical record for Resident B was reviewed on 6/16/25 at 5:30 P.M. A Quarterly Minimum Data Set (MDS) Assessment, dated 04/11/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, non-Alzheimer's dementia, and malnutrition. A Progress Note, dated 05/23/25 at 6:15 P.M., indicated the resident was noted to have some swelling and discoloration to the right lower leg. The Nurse Practitioner (NP) was notified, and a new order was obtained for a STAT (immediately) x-ray of the knee, ankle, and extended tibia/fibula. A Progress Note, dated 05/24/25 at 12:40 P.M., indicated the resident's x-ray was obtained and a new order was received to send the resident to the local emergency room. A Radiology X-Ray Report, dated 05/24/25 at 12:23 P.M., indicated the resident had a two view, right tibia and fibula x-ray. During an interview, on 06/26/25 at 6:58 P.M., RN 3 indicated she was working the night the NP ordered a STAT x-ray for Resident B. She had been working all night until 6:00 A.M. the next morning and the technician never came on her shift. She had instructed that the staff to not get the resident out of bed due to not having the x-ray completed. She believed over 12 hours was an unacceptable time frame for a STAT x-ray to be completed. During an interview, on 06/17/25 at 10:40 A.M., Licensed Practical Nurse (LPN) 4 indicated a STAT x-ray should be obtained within a couple of hours. During an interview, on 06/17/25 at 11:39 A.M., the Assistant Director of Nursing (ADON) indicated a STAT x-ray should be obtained within four hours of getting the order. The NP ordered a STAT x-ray for Resident B on 05/23/25 around 6:00 P.M. and the technician did not come until the next day. The current facility policy titled, Guidelines for Diagnostic Services, dated 07/14/23, was provided by the ADON on 06/17/25 at 1:37 P.M. The policy indicated, .It is the policy of this facility to ensure that laboratory, radiology, and other diagnostic services meet the needs of residents, that results are reported promptly to the ordering provider to address potential concerns and for disease prevention, provide for resident assessment, diagnosis, and treatment, and that the facility has established policies and procedures and is responsible for the quality and timeliness of services whether services are provided by the facility or an outside resource . This citation relates to Complaint IN00460383. 3.1-49(a)

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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 record review and interview, the facility failed to document a resident's behaviors for 1 of 3 residents reviewed for medical records. (Resident B) Findings include: During an interview, on 06/16/25 at 6:46 P.M., Certified Nurse Aide (CNA) 5 indicated Resident B had been having more behaviors during care for the last two to three weeks related to kicking her legs. The CNAs didn't have access to document a resident's behaviors. The CNAs had to let the nurse know and the nurse would document on the resident's record. She had told Licensed Practical Nurse (LPN) 4 and LPN 6 about the resident's behavior related to kicking her legs. During an interview, on 06/17/25 at 10:40 A.M., LPN 4 indicated the resident had some behaviors of kicking during care. The resident behaviors would be documented in the Electronic Medication Administration Record/Electronic Treatment Administration Record (EMAR/ETAR) or a progress note. During an interview, on 06/17/25 at 11:39 A.M., the Assistant Director of Nursing (ADON) indicated after interview staff, from 05/24/25 through 05/29/25. It was determined the resident was having increased behaviors during care and was kicking during care. She was unsure if the behaviors were documented. The CNAs were not able to document resident behaviors and should have told the nurse. The nurse would document resident behaviors in a progress note. The clinical record for Resident B was reviewed on 6/16/25 at 5:30 P.M. A Quarterly Minimum Data Set (MDS) Assessment, dated 04/11/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, non-Alzheimer's dementia, and malnutrition. A physician's order, dated 12/22/23 through 06/17/25, indicated the staff were to monitor the resident's behavior every shift. The May 2025 EMAR/ETAR indicated to see the Progress Notes on the following dates and times: - On 05/03/25 at night, - On 05/04/25 at night, - On 05/08/25 at night, - On 05/09/25 at night, - On 05/13/25 at night, - On 05/14/25 at night, - On 05/17/25 at night, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 05/18/25 at night, and - On 05/21/25 at night. The May 2025 Progress Notes lacked any documented behaviors for the resident. The current facility policy titled, Guidelines for Addressing/Managing Resident Who-----Refuse Care or Who Are NON-ADHERENT TO THEIR CARE PLAN dated 10/11/2024, was provided by the ADON on 06/17/25 at 1:39 P.M. The policy indicated, .DOCUMENT DOCUMENT DOCUMENT .It cannot be stressed enough that THROUGH DOCUMENTATION IS CRITICAL . The current facility policy titled, Guidelines for Handling and Addressing Behavioral Emergencies, dated 03/18/23, was provided by the ADON on 06/17/25 at 11:35 A.M. The policy indicated, .Documentation . Record specifics related to the behavior incident .Documentation in the clinical record should include facts as related to time, possible causative factors, actual behavior with the consequences, interventions and outcomes . This citation relates to Complaint IN00460383. 3.1-50(a)(2)