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	07/18/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview and record review, the facility failed to ensure residents were treated with respect and dignity related to Activities of Daily Living (ADL) care and monitoring inventory of personal belongings for 4 of 9 residents reviewed for resident rights. (Residents B, C, K, and L) Findings include:1. During an interview and observation, on 07/17/25 at 10:17 A.M., Resident B indicated she was bruised during ADL care a couple of weeks ago. Staff members had come into her room early in the morning, after breakfast, and said she was going to take a shower. The resident held onto the grab bar on the side of the bed and kept saying she refused. The staff peeled her fingers off her side grab bar and proceeded to use the mechanical lift, transferred her to a shower chair, and forced her to take a shower. The resident indicated she was just bruised on her hands. There were no visible bruises observed to the resident's hands. The resident indicated she gave one of the aides a good titty twister when they got one of her hands loose, she should not have touched the aide, she was just angry. She had not been bruised during care in the past. Her shower days were Wednesdays and Saturdays. The staff that were working with her were Certified Nurse Aide (CNA) 2 and CNA 3. The clinical record for Resident B was reviewed on 07/18/25 at 1:08 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 04/18/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, hypertension, anxiety, chronic pain syndrome, and depression. The resident was dependent on staff members to assist her with bathing and required maximal assistance. An Interdisciplinary Team (IDT) note, dated 06/30/25, indicated the resident had discoloration to her left forearm and right knuckle. The root cause of the discoloration was determined to be due to the resident grabbing on to the breast of a staff member, twisting, and pulling. Staff had to remove the resident's hand off the staff member's breast, on 06/25/25. Additional factors included the enabler bars the resident used to promote mobility and the use of Xarelto (a blood thinning medication) increasing risks of bruising During an interview, on 07/18/25 at 1:35 P.M., the DON indicated the resident had bruising on her arm. Multiple times, the resident thought it was from her bed, then she thought it happened during a shower. The facility did resident and staff interviews and had nothing substantiated. The resident indicated she did not want CNA 3 to give her a shower, which was typical of Resident B, she would choose who she didn't want to help her. For that instance, CNA 2 put the resident in the shower and gave her a shower. The resident was in the shower chair, holding on to the bed rail, and they were afraid she would fall out of the chair. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 07/17/25 at 10:38 A.M., CNA 2 indicated if a resident was resistive to care or refusing care, staff were not to force them. Residents were to be encouraged to allow staff to provide care. If a resident was resistive or combative with care, staff were to stop and then come back a little later to try again. They might have a different staff member attempt to provide care. If the resident still refused, the aides were to notify the nurse. During an interview, on 07/17/25 at 12:25 P.M., CNA 2 indicated, a couple of weeks ago, in regard to the day in question, she was going to assist Resident B with a shower. CNA 2 left the resident’s room and went to get the shower chair. CNA 3 was in the room with the resident. When CNA 2 came back, the resident was mad at CNA 3 and said she did not want CNA 3 to give her a shower. CNA 2 told the resident she was going to give the resident the shower, not CNA 3. The resident was super mad; she kept saying things. CNA 2 could not recall what she was saying, she was just trying to calm the resident down. CNA 3 remained in the resident’s room. At some point the resident grabbed CNA 3’s breast. The CNAs had to remove the resident’s hand from CNA 3’s breast. The resident was still in bed, and the CNAs were putting the mechanical lift pad under the resident. The resident was holding on to the bed railing. They told her to let go of the railing. CNA 2 removed the resident’s fingers from the railing. She could not remember what the resident was saying, she kept saying she didn’t want CNA 3 to give her a shower. The CNAs got the resident into the shower chair. The resident said she was going to yell all the way down the hall to the shower room, and she did. Once CNA 2 got the resident into the shower, she was fine. She was able to shower the resident and wash her hair without difficulty. She assisted the resident with combing her hair after the shower. During an anonymous interview, a staff member indicated residents were not allowed to refuse care. Staff were not allowed to document that a resident refused care. The staff member thought residents had the right to refuse, but there had been instances when they were told they had to provide care even if the resident refused. The current facility policy, titled GUIDELINES FOR OBSERVING AND IMPLEMENTING - RESIDENT RIGHTS, dated 07/12/23, was provided by the Regional Director of Operations on 07/18/25 at 2:07 P.M. The policy indicated, .7) It is important that staff be aware of the RESIDENT RIGHTS to include but not limited to: A dignified existence - resident being treated with dignity in all situations . Residents are to have their well-being and self-esteem, and self-worth enhanced during all care and services interactions .1. Staff will treat each resident with respect and dignity .3. Staff will not use any profanity or vulgar words in the presence of the resident and under no circumstances directed at the resident . 2a. During an interview, on 07/18/25 at 10:45 A.M., Resident K indicated he was missing a blue blanket with sharks on it that his family brought him. He was unsure if the blanket was on an inventory list. The resident’s clinical record was reviewed on 07/17/25 at 1:48 P.M. A Quarterly MDS assessment, dated 04/15/25, indicated the resident was moderately cognitively impaired. The resident’s diagnosis included, but were not limited to, stroke, hemiplegia, and malnutrition. The resident’s record lacked an inventory list of personal items. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b. During an interview, on 07/17/25 at 2:11 P.M., Resident C indicated she had a name brand purse that was missing. Her family member had hung the purse out of view in the back of the closet. She realized it was gone a few weeks ago. The clinical record for Resident C was reviewed on 07/17/25 at 12:29 P.M. A Quarterly MDS assessment, dated 06/03/25, indicated the resident was cognitively intact. The resident’s diagnoses included, but were not limited to, stroke, hypertension, diabetes, and depression. The resident’s record lacked an inventory list of personal items. 2c. During an interview, on 07/17/25 at 2:55 P.M., Resident L indicated she was not missing any personal items. Staff labeled clothing with residents’ names. She did not think the facility made an inventory list of her belongings when she was admitted . Resident L’s clinical record was reviewed on 07/18/25 at 1:10 P.M. An admission MDS assessment, dated 04/14/25, indicated the resident was severely cognitively impaired. The resident’s diagnoses included, but were not limited to, stroke, hypertension, and diabetes. The resident’s record lacked an inventory list of her personal items. During an interview, on 07/18/25 at 11:31 A.M., the Housekeeping Supervisor indicated she could not find inventory lists of residents’ belongings. The previous Housekeeping Supervisor, that left a few months ago, was supposed to be taking care of inventory lists. All resident records should be in the computer; they didn’t have hard charts. She could find no documentation of any resident’s belongings. Inventory lists of residents’ belongings, should include, but would not be limited to, clothing, purses, shoes, personal electronics, etc. The current, undated facility policy, titled “Policy and Procedure, Resident Personal Clothing and Belongings Handling” was provided by the DON on 07/18/25 at 2:07 P.M. The policy indicated, “…To ensure that all resident’s clothing are identified, stored, and laundered appropriately…Personal Belonging are to be listed on the Belongings List in the resident’s chart…” This citation relates to Complaints 2561987 and 2560828. 3.1-3(t) 3.1-9(g)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to treat and identify pressure ulcers in a timely manner for 1 of 3 residents reviewed for pressure ulcers. (Resident C)Findings include:During an observation, on 07/18/25 at 10:19 A.M., Qualified Medication Aide (QMA), answered Resident C's call light. The resident indicated she needed to get off the bed pan. The Assistant Director of Nursing (ADON) assisted the QMA to get the resident off the bed pan. The ADON cleansed the resident and left the room. She returned with a cream and applied it to the resident's bottom. She told the resident she didn't put the cream on her wounds just around them because the wounds would need a treatment put in place. The resident had a wound to the right posterior thigh that was pink in color with to drainage. The wound was pea size and did not have a dressing in place. The resident also had a wound on the coccyx that was a slit that was approximately the size of pencil lead. The wounds were shown by the ADON. The staff applied a brief and dressed the resident with pants. The staff told the resident that they would let the Certified Nurse Aides (CNA)'s know that she was ready to get up. They left the room and alerted the CNA's that the resident was ready to get up. The resident's wounds did not have treatments in place before the QMA and the ADON left the room, and the resident was left laying on her back.During an observation, on 07/18/25 at 11:01 A.M., the ADON returned to Resident C's room and indicated that she was going to apply a dressing to her wounds. The resident was rolled to her left side, her pants and brief were removed, and a treatment was applied to the resident's right posterior thigh. The resident's brief was reapplied, her shorts were pulled up, and the resident's full body mechanical lift pad was hooked up to the lift. The nurse was questioned about the coccyx wound not having a treatment in place at that time.During an interview, on 07/18/25 at 11:08 A.M., the ADON indicated she was unsure if the resident had an order for the coccyx wound. If she did, she must have missed it when she checked the orders. If she did have an order, then she would wait and apply the dressing after lunch. The resident had a pressure reducing cushion in her wheelchair. The ADON went to the resident's room and asked the resident if she was ok to wait for a minute so she could recheck her orders for a treatment to her coccyx. She indicated to the resident that she didn't want her sitting up without a treatment in place.During an interview, on 07/18/25 at 11:11 A.M., the ADON indicated the resident had a treatment to the coccyx and she would get the supplies and apply it before she got out of bed.During an observation, on 07/18/25 at 11:15 A.M., the ADON returned to the resident's room and applied the treatment to the coccyx. The clinical record for Resident C was reviewed on 07/17/25 at 12:29 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 06/03/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, stroke, hypertension, diabetes, and depression. The resident was at risk for pressures ulcer with no pressure ulcers identified at the time of the assessment.A Facility Weekly Skin Check, dated 07/15/25, indicated the resident had an existing area of loss but did not have any new skin loss of skin integrity.A Shower Sheet, dated 07/14/25, indicated the resident had no new skin concerns.A Wound Nurse Practitioner (NP) Wound Assessment Report, dated 07/16/25, indicated the resident had a facility acquired Stage 3 (Full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss.) pressure ulcer to the right posterior thigh, that was acquired on 07/15/25.During a family interview, on 07/17/25 at 1:50 P.M., they indicated that the resident would frequently go without treatments to their wounds.During an interview, on 07/18/25 at 10:06 A.M., CNA's 6 and 7 indicated they would monitor resident's skin daily during care and during their showers. If they noticed any skin concerns, they would alert their nurse. The only place they had to documented skin concerns was on their shower sheets.During an interview, on 07/18/25 at 10:09 A.M., Licensed Practical Nurse (LPN) 4 indicated resident's skin assessments were completed weekly by the nurse and the CNAs would monitor it during care daily. If she was aware of a new skin impairment then she would assess it, notify the wound nurse, and retrieve new orders.During an interview, on 07/18/25 at 1:31 P.M., the Director of Nursing (DON) indicated the thigh wound for the resident was identified by the Wound NP. The staff should have potentially saw the wound before it was a Stage 3.The current facility policy, dated 10/09/23, titled GUIDELINES FOR PREVENTION/TREATMENT OF PRESSURE INJURIES policy, indicated .The policy indicated, .based on resident assessment, the facility will ensure .A resident receives care, consistent with professional standards of practice; to prevent pressure ulcers .A Risk Assessment is considered the starting point for prevention of pressure injury. It is important to note and at risk resident can develop a pressure injury within hours of the

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to Enhanced Barrier Precautions (EBP) for 2 of 2 wound care observations. (Residents C and F) Findings include:1.During an observation, on 07/18/25 at 11:01 A.M., the Assistant Director of Nursing (ADON) entered Resident C’s room and indicated that she was going to apply a dressing to her wounds. The resident was rolled to her left side, her pants and brief were removed, and a treatment was applied to the resident’s right posterior thigh. The resident’s brief was reapplied, her pants were pulled up, and the resident’s full body mechanical lift pad was hooked up to the lift. The nurse was questioned about the coccyx wound not having a treatment in place at that time. The ADON nor the Certified Nurse Aide (CNA) in the room had donned gowns prior to the treatment of the right posterior thigh wound. During an observation, on 07/18/25 at 11:15 A.M., the ADON returned to the resident’s room and applied the treatment to the coccyx. The ADON nor the CNA had donned gowns prior to the treatment of the wound. The resident lacked a sign on her door indicating she was on EBP during the survey from 07/17/25 through 07/18/25. The clinical record for Resident C was reviewed on 07/17/25 at 12:29 P.M. The record lacked a physician's order for EBP. 2. The clinical record for Resident F was reviewed on 07/18/25 at 11:45 A.M. A Quarterly MDS assessment, dated 06/05/25, indicated the resident was severely cognitively impaired. The residents’ diagnoses included, but were not limited to, hypertension, dementia, anxiety, and depression. The resident had a chronic pressure wound on her right heel. The clinical record lacked a physician’s order for the resident to be in EBP for wound care. During an observation, on 07/18/25 at 12:55 P.M., Licensed Practical Nurse (LPN) 4 entered the resident’s room, donned gloves, pulled back the heel dressing and exposed a small pinpoint sized wound. She placed the dressing back in place and pulled a sock over the resident’s heel and ankle. The LPN failed to wear a gown during the wound care. The resident’s door lacked a sign indicating she was in EBP. There was no PPE, other than gloves, outside or inside the resident’s room. During an interview, on 07/18/25 at 1:31 P.M., the Director of Nursing (DON) indicated residents with significant or chronic wounds, urinary catheters, and any indwelling tubes should be in EBP. Residents C and F should have been in EBP because they had chronic pressure wounds. The current facility policy titled, Guidelines for Enhance Barrier Precautions, was provided by the Director of Nursing on 06/03/25 at 3:18 P.M. The policy indicated, .It is the policy of the facility to ensure that additional and appropriate PPE [Personal Protective Equipment] is utilized, when indicated, to prevent the spread of Multidrug-resistant Organisms .Enhanced Barrier Precautions are defined as the use of PPE [gowns and gloves] during high-contact resident care activities . This citation relates to Complaint 2561987. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-18(b)