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	03/06/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 33613 Based on record review and interview, the facility failed to follow the physician's orders related to medication hold parameters (Resident 13) and implement fall interventions of non-skid strips (Resident 54) for 2 of 20 residents reviewed for Quality of Care. Findings include: 1. The clinical record for Resident 13 was reviewed on 03/05/25 at 10:26 A.M. An Annual Minimum Data Set (MDS) assessment, dated 01/15/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, hypertension, dementia, anxiety, and depression. A current open-ended physician's order, with a start date of 01/08/25, indicated the resident was to receive Losartan (a blood pressure medication) 25 milligrams (mg), one time a day. The staff were to hold the medication when the systolic blood pressure (SBP) was less than 110 or the diastolic blood pressure (DBP) was less than 70. The January and February 2025 Electronic Medication Administration Record (EMAR) indicated the resident received the medication when the blood pressure was either not obtained, when the SBP was less than 110, or when the DBP was less than 70 on the following dates: - On 01/08/25 the resident's blood pressure was not obtained, - On 01/10/25 the resident's blood pressure was not obtained, - On 01/11/25 the resident's blood pressure was not obtained, - On 01/13/25 the resident's blood pressure was not obtained, - On 01/14/25 the resident's blood pressure was not obtained, - On 01/15/25 the resident's blood pressure was not obtained, - On 01/16/25 the resident's blood pressure was not obtained, - On 01/17/25, the resident's blood pressure was not obtained, (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 01/18/25 the resident's blood pressure was not obtained, - On 01/19/25 the resident's blood pressure was not obtained, - On 01/20/25 the resident's blood pressure was not obtained, - On 01/21/25 the resident's blood pressure was not obtained, - On 01/22/25 the resident's blood pressure was not obtained, - On 01/23/25 the resident's blood pressure was not obtained, - On 01/24/25 the resident's blood pressure was not obtained, - On 01/25/25 the resident's blood pressure was 131/69, - On 01/26/25 the resident's blood pressure was not obtained, - On 01/27/25 the resident's blood pressure was not obtained, - On 01/28/25 the resident's blood pressure was not obtained, - On 02/19/25 the resident's blood pressure was 120/67, - On 02/23/25 the resident's blood pressure was 124/68, - On 02/24/25 the resident's blood pressure was 11/64 and, - On 02/25/25 the resident's blood pressure was 115/68. During an interview, on 03/06/25 at 2:14 P.M., Qualified Medication Aide (QMA) 5 indicated if a resident's blood pressure medication had hold parameters, she would check the resident's blood pressure just prior to giving the medication. If the blood pressure was outside the parameters, she would hold the medication and document on the EMAR why it was held. The current facility policy titled MEDICATION ADMINISTRATION, dated July 2024, was provided by the Director of Nursing (DON) on 03/05/25 at 3:04 P.M. The policy indicated, .To administer all medications safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis . 2. Resident 54 was observed in his room on 03/04/25 at 9:24 A.M. The resident was standing near his recliner and putting a sweater on to go outside. There were no non-skid strips on the floor near the recliner. The resident was observed in his room on 03/05/25 at 12:40 P.M. The resident was sitting in his recliner. The resident indicated he recently fell outside but was usually steady on his feet. There were no non-skid strips on the floor near the resident's recliner. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's clinical record was reviewed on 03/06/25 at 9:59 A.M. An Annual Minimum Data Set assessment, dated 02/06/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, a traumatic brain injury, diabetes, and bipolar disorder. The resident experienced one fall without injury since the last assessment. A Progress Note, dated 11/29/24 at 11:40 A.M., indicated the resident was putting the footrest down on his recliner when he slid out of the recliner and onto the floor in front of the chair. The resident was not injured. A Progress Note, dated 12/02/24 at 10:45 A.M., indicated the fall was reviewed and an intervention to install non-skids strips on the floor near the recliner was initiated. The resident's current Fall Care Plan indicated an intervention was initiated on 12/02/24 to place non-skid strips on the floor by the resident's recliner. During an interview on 03/06/25 at 10:07 A.M., Certified Nurse Aide 6 indicated fall interventions were listed in the computer in the residents' Care Plans. The resident's interventions included non-skid strips on the floor near the resident's recliner. The CNA observed the resident's room and indicated there were no non-skid strips on the floor near the recliner. The resident had recently moved rooms. The strips should have been placed on the floor after the room change. The current facility policy, titled GUIDELINES FOR INCIDENTS/ACCIDENTS/FALLS, dated 06/30/23, indicated, .All falls will have a site investigation .to define root cause of the fall .Each fall needs a new care plan intervention rolled out . 3.1-45(a)(2) 3.1-37(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38239 Based on observation, interview, and record review, the facility failed to promptly identify and treat a pressure wound infection in a timely manner for 1 of 3 residents reviewed for pressure ulcers/skin impairments. (Resident 64) Findings include: An Admission Minimum Data Set assessment, dated 08/23/24, indicated Resident 64 was cognitively intact. The resident's diagnoses included, but were not limited to, non-traumatic spinal cord dysfunction, heart failure, multi-drug-resistant organism infection, diabetes, paraplegia, and malnutrition. The resident was at risk for pressure ulcers and had an unhealed Unstageable (Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer upon admission. The resident utilized pressure reducing devices for the bed and chair, and pressure ulcer treatments were administered. A Skin and Wound Note, dated 08/19/24, indicated the resident's prior medical history included a hospitalization in July and August of 2024 for abdominal pain and altered mental status. The patient was found to have meningitis, osteomyelitis (bone infection), and an intraspinal abscess. The patient received intravenous antibiotics. The patient developed an unstageable pressure ulcer while in the hospital, prior to his admission to the facility. The Wound NP's initial assessment indicated the wound measured 7 cm x 7 cm, with a depth of 0.3 cm. The wound base was 30% granulation tissue and 70% slough. There was a scant amount of serosanguinous (pale red to pink, thin, and watery) drainage. A Skin and Wound note, dated 09/03/24, indicated the resident developed a new pressure ulcer on the left buttock. The wound was an evolving Deep Tissue Injury (Persistent non-blanchable deep red, maroon, or purple discoloration of intact skin). The wound measured 6 cm x 4.5 cm, with a depth of 0.1 cm. The wound bed was 60% granulation tissue and 40% slough, with a moderate amount of serosanguineous drainage. A Skin and Wound note, dated 09/09/24, indicated the resident had a new pressure ulcer on the right buttock identified. The wound was a Stage III pressure ulcer that measured 4 cm x 3.8 cm, with a depth of 0.3 cm. The wound bed was 50% granulation tissue and 50% slough. There was a scant amount of serous drainage. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview, on 03/05/25 at 10:45 A.M, Resident 64's pressure ulcers were observed with the Facility Wound Nurse and the Wound Nurse Practitioner (Wound NP). The resident's sacral wound was currently classified as a Stage IV (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough [non-viable, usually moist tissue] and/or eschar [dry, dead tissue] may be visible on some parts of the wound bed) that measured 5.9 centimeters (cm) x 6.5 cm, with a depth of 0.6 cm. The wound bed was pinkish red, with 90% granulation (new/healing) tissue, and 10% slough. There was no drainage or signs of infection. The pressure ulcer on the resident's left buttock was a Stage III (Full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue was often present. Slough and/or eschar [dry dead tissue] may be visible but would not obscure the depth of tissue loss) that measured 5 cm x 4.9 cm, with a depth of 0.3 cm. The wound bed was pinkish red with 70% granulation tissue and 30% yellow slough present. There was no drainage or signs of infection. At 10:51 A.M., the Wound NP indicated the resident's sacral wound was present when the resident was admitted to the facility back in August of last year. The resident's left buttock wound developed in the facility a few weeks after admission. Another Stage III wound developed on the resident's right buttock around the same time, but that wound healed rather quickly. The resident was on several antibiotics when he was admitted to the facility for various infections and spent several weeks in the hospital related to infections shortly after admission. They had tried many different treatments for the resident's wounds, and they have improved significantly. There were no current infections. During an interview, on 03/06/25 at 11:25 A.M., the Wound NP indicated the resident's sacral wound was unstageable when he discharged from the facility to the hospital on 09/18/24. When the resident returned to the facility on [DATE], the sacral wound was categorized as a Stage IV. The left buttock wound was classified as an evolving DTI on the initial wound assessment dated [DATE]. There was purple discoloration of an intact area of skin, open skin with granulation tissue, and slough present. Ideally, every wound should be identified before the skin was non-blanchable (skin doesn't turn white when pressed, a clinical sign of pressure damage) and before slough was present. A Skin and Wound Note, dated 12/09/24, indicated the resident's sacral wound measured 8.2 cm x 8 cm, with a depth of 1.4 cm. The wound base was 90% granulation and 10% slough. There was a mild odor after the wound was cleansed. A Progress Note, dated 12/09/24, indicated there was a new physician's order to obtain a wound culture. A Skin and Wound note, dated 12/16/24, indicated the wound culture from 12/09/24 was reviewed that day. The culture was positive for heavy growth of proteus mirabilis and beta hemolytic streptococci. The Wound NP recommended Augmentin (an antibiotic) by mouth, twice a day for fourteen days for continued wound infection. A Nursing Progress Note, dated 12/16/2024, indicated the NP was in to see the resident and gave a new order for Augmentin. An Antibiotic Therapy Note, dated 12/17/24, indicated the resident was to receive Augmentin 850 milligrams for fourteen days for a wound infection. The wound was noted to have gross drainage with a strong odor. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/25 at 11:14 A.M., the Director of Nursing indicated typically, when the facility sent a sample out to the lab, they would get the results via fax. Cultures usually took 48 to 72 hours. The wound culture was sent out on 12/09/24, but they didn't get the results until 12/16/24. It should have been followed up on. 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 onset of pressure. For this reason, the at risk resident must be identified, and have specific interventions put promptly in place and care planned in an effort to prevent formation of a pressure injury . 3.1-40(a)(2)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 38239 Based on interview and record review, the facility failed to ensure a resident's food preferences were identified and replacement meal options were offered for 1 of 3 residents reviewed for nutrition. (Resident 76) Findings include: During an interview, on 03/03/25 at 11:19 A.M., Resident 76 indicated he was recently admitted to the facility, and he did not like the food. They brought him eggs and sausage for breakfast, and sometimes oatmeal. He did not like to eat any of those things for breakfast. He was used to eating dry cereal with milk and fruit every day for breakfast at home. He liked to drink his coffee with his breakfast, not before breakfast. They always brought it before the meal, and it was cold by the time he got the food. He just didn't eat breakfast anymore. No one ever came and asked him about what food he liked or didn't like. He had been there a little over two weeks. During an interview on 03/04/25 at 10:27 A.M., the Dietary Manager indicated when a resident was admitted to the facility she would usually go and talk to them within a few days to find out what they liked and didn't like to eat. The information would be entered into the computer and would print out on the resident's tray ticket. Staff would use the information to prepare the resident's meals. The Dietary Manager looked in the computer and indicated there was no information entered in to address the resident's likes or dislikes. She did not remember if she talked to him when he came to the facility, she may have missed him. She should have talked to him by now. The resident's clinical record was reviewed on 03/06/25 at 9:16 A.M. An Admission Minimum Data Set assessment, dated 2/17/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, coronary artery disease, atrial fibrillation, heart failure and hypertension. The resident was 6 feet tall and weighed 175 pounds. The resident had no problems with eating or swallowing. The resident's Care Plans indicated he was to receive his diet as ordered. The interventions included, but were not limited to; dated 02/14/25, staff were to offer the resident substitutions when the resident consumed fifty percent or less of a meal. During an interview, on 03/06/25 at 10:07 A.M., Certified Nurse Aide 6 indicated aides were to document how much a resident ate for each meal in the computer. If they didn't eat much, staff would encourage them to eat and offer the resident something else. That would be documented in a separate section in the computer (replacement meal). They would let the nurse know when the resident did not each much. The resident's meal intake records since his admission to the facility were reviewed and indicated on the following dates and times the resident ate 50% or less of his meal and he was not offered a replacement meal: - The resident ate between 26% and 50% at breakfast and supper on 02/14/25, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident ate between 26% and 50% at lunch on 02/15/25, - The resident refused breakfast on 02/18/25, - The resident ate between 26% and 50% for supper on 02/21/25, there was no documentation for breakfast or lunch, - The resident refused breakfast and lunch on 02/22/25, - The resident refused breakfast and lunch on 02/23/25, - The resident refused breakfast and ate between 26% and 50% for lunch on 02/24/25, - The resident ate between 26% and 50% for lunch on 02/25/25, - The resident ate between 0% and 26% for supper on 02/26/25, - The resident refused breakfast on 02/28/25, - The resident ate between 0% and 26% for breakfast and refused lunch on 03/02/25, - The resident refused breakfast on 03/03/25, and - The resident ate between 26% and 50% for breakfast and refused lunch on 03/06/25. The current, undated facility policy, titled Resident Food Preferences indicated .Upon the resident's admission or within seventy-two (72) hours after his/her admission, the dietary professional or nursing staff will identify a resident's food preferences . 3.1-21(a)(4)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34232 Based on observation, interview, and record review, the facility failed to ensure a resident's medications were available for 1 of 5 residents observed for pharmacy services. (Resident 33) Findings include: Medication administration was observed on [DATE] at 10:56 A.M., with Licensed Practical Nurse (LPN) 4. As the nurse prepared medications for Resident 33, she discovered the resident did not have the physician prescribed Gabapentin 200 milligrams (mg) available. The resident was to receive two 100 mg tablets. The LPN indicated they had gotten a big shipment of medications that morning. The LPN indicated they would do a refill request, and the medication would come in that night. The resident was to receive Gabapentin 200 mg at 11:00 A.M. and at 4:00 P.M. The LPN checked the resident's record and indicated the resident's 200 mg dose was ordered on [DATE] and had not been reordered since. The medication cards usually held 30 pills. She did not know where the list was indicating what medications were delivered on [DATE]. The clinical record for Resident 33 was reviewed on [DATE] at 10:43 A.M. A Quarterly Minimum Data Set assessment, dated [DATE], indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, Gastroesophageal Reflux Disease (GERD), stroke, hypertension, diabetes, Chronic Obstructive Pulmonary Disease (COPD), and respiratory failure. The February and March Electronic Medication Administration Record/Electronic Treatment Administration Record (EMAR/ETAR) and the Progress Notes indicated the resident did not receive the following medications on the following dates and times, and for the following reasons: - On February 4 and 5, 2025, the resident's had not received her Losartan Potassium 50 milligrams (mg), one tablet by mouth in the morning for hypertension. The facility was waiting on the pharmacy to deliver the medication. - On February 19, 2025, the resident had not received her Famotidine 20 mg, one tablet by mouth in the morning for GERD. The facility was waiting on the pharmacy to deliver the medication. - On February 19, 2025 at 9:10 A.M., the resident had not received her Metformin 500 mg, one tablet by mouth every morning and at bedtime for diabetes. The facility was waiting for the pharmacy to deliver the medication. - On February 21, 22, 24, and 25, 2025, the resident had not received her Anoro Ellipta inhaler, one puff, inhale orally in the morning for COPD. The facility was waiting for the pharmacy to deliver the medications. - On February 21, 2025, the resident had not received her Cholestyramine 4 grams, one packet by mouth in the morning for diarrhea. The facility was waiting for the pharmacy to deliver the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On February 24, 2025, the resident had not received her Lasix 20 mg, one tablet by mouth in the morning for edema. The facility was waiting for the pharmacy to deliver the medication. - On [DATE], the resident had not received her Jardiance 10 mg, one tablet by mouth in the morning for diabetes. The facility was waiting for the pharmacy to deliver the medication. - On [DATE] at 9:35 A.M., the resident had not received her Metoprolol 12.5 mg, by mouth every morning and at bedtime for hypertension. The facility was waiting for the pharmacy to deliver the medication. - On [DATE] at 11:00 A.M. and 4:00 P.M., the resident had not received her Gabapentin 100 mg, give 200 mg by mouth three times a day for neuropathy. The resident's medication was not available. The resident's pain level was monitored twice a day and had been rated at a zero out of ten on [DATE], 3, and in the morning of [DATE]. On night shift of [DATE], the resident rated their pain at a three out of ten. The start date for the above listed physician's orders were in February of 2024 or before. None of the medications were new orders for this resident. During an interview on [DATE] at 10:50 A.M., Resident 33 indicated she had pain in her left shoulder and the left side of her neck. During an interview on [DATE] at 2:03 P.M., the Assistant Director of Nursing (ADON) indicated the pharmacy delivered medications to the facility twice a day, every day of the week. The nurse working on the floor was responsible for ordering residents' medications. They can call the pharmacy, fax the pharmacy, or reorder medications using the computer system. The staff can order while passing medications if they see the resident getting low on a medication. The cut off time for ordering medications was 6:00 P.M. on the day before, to receive medications the following morning. Medications are generally received by 8:00 A.M., less than 24 hours after ordering them. If they ordered after 6:00 P.M., they should arrive within a day and a half. The staff can reorder medications with the click of a button. They may have to call to check if a resident had a refill on a narcotic, but most other medications they could order without calling. Medications usually came on cards of 30. Resident 33 had orders that expired per the ADON's phone call with the pharmacy, even though the facility order was still active. The pharmacist told the ADON that the facility just had to call, and the pharmacy just had to click a button to order the medication. The ADON did not monitor what medications were ordered daily. She was not aware of any staff member who monitored what medications were ordered each day. The nurse working on the floor could call the pharmacy for medications. The current undated CUBEX STATION POLICIES AND PROCEDURES policy was provided by the Director of Nursing (DON) on [DATE] at 3:04 P.M. The policy indicated, .Nursing and pharmacy staff will use the CUBEX Station as an inventory, charging and information system for the control and distribution of medications for emergency, first-dose use and other situations where medications are not readily available from the pharmacy until the next scheduled delivery. The CUBEX Station is not intended to be a source of medications for continuous dosing i.e. routine and scheduled medications . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current undated RESIDENT RIGHTS policy was provided by the DON on [DATE] at 3:04 P.M. The policy indicated, .Accommodation of Needs .They have the right to receive services with reasonable accommodations to individual needs . 3XXX,d+[DATE](g)(2) 3XXX,d+[DATE](g)(3) 3XXX,d+[DATE](a)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34232 Based on observation, interview, and record review, the facility failed to store medications appropriately related to vials of insulin for 2 of 3 medication carts reviewed. (Station 3 Medication Cart 2 and Station 2 Medication Cart) Findings include: 1. Medication Cart 2 on Station 3 was observed on [DATE] at 9:23 A.M., with Licensed Practical Nurse (LPN) 2, and included the following: - A Fiasp/Aspart insulin vial for Resident 3, that was ,d+[DATE] full. The delivery date on the storage bottle was [DATE]. No open date was on the vial or the storage bottle. The LPN indicated the resident received the insulin four times a day per a sliding scale, but he had not received it yet that day. - A Lispro insulin vial for Resident 64, that was ,d+[DATE] full. The delivery date on the storage bottle was [DATE]. No open date was on the vial or the storage bottle. The LPN indicated the resident no longer used the insulin and it should have been removed from the cart. The clinical record for Resident 64 indicated his Lispro insulin had been discontinued on [DATE]. During an interview, on [DATE] at 9:38 A.M., LPN 2 indicated insulin pens and vials should be dated when opened and labeled with an expiration date. 2. The Medication Cart on Station 2 was observed on [DATE] at 9:46 A.M., with Qualified Medication Aide (QMA) 3, and included the following: - A Lantus insulin vial for Resident 35, that was ,d+[DATE] full. The box the vial was in was dated [DATE]. The vial was not dated. QMA 3 indicated insulin was usually good for 30 days. - A Lantus insulin vial for Resident 40, that was over ,d+[DATE] full. The box the vial was in was dated [DATE]. The vial was not dated. The QMA indicated she did not manage the insulin for the residents, the nurse was responsible for the use of the insulin. The Medication Room was observed, on [DATE] at 9:54 A.M., with QMA 3. A small refrigerator in the room had a sign on the front reminding nursing staff to date insulin containers when they were opened. QMA 3 indicated they did not keep insulin in that refrigerator anymore. The Lantus insulin package insert was provided by the Director of Nursing (DON) on [DATE] at 3:04 P.M. The record indicated, .The LANTUS vials you are using should be thrown away after 28 days, even if it still has insulin left in it . The Fiasp insulin package insert was provided by the DON on [DATE] at 2:54 P.M. The record indicated an open vial in use expired after 28 days. (continued on next page)

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	03/06/2025

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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The current MEDICATION STORAGE IN THE FACILITY policy, dated [DATE], was provided by the DON on [DATE] at 3:04 P.M. The policy indicated, .Facility staff will assure that the multi-dose vial is stored following manufacturer's suggested storage conditions .If the medication is discontinued or outdated, remove medication from [sic] proper disposal . 3XXX,d+[DATE](j)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38239 Based on record review and interview, the facility failed to obtain a wound culture in a timely manner for 1 of 2 residents reviewed for infections. (Resident 64) Findings include: Resident 64's clinical record was reviewed on 03/05/25 9:57 A.M. An Admission Minimum Data Set assessment, dated 08/23/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, non-traumatic spinal cord dysfunction, heart failure, multi-drug-resistant organism infection, diabetes, paraplegia, and malnutrition. The resident was at risk for pressure ulcers and had an unhealed pressure ulcer upon admission. A Skin and Wound Note, dated 12/09/24, indicated the resident's sacral wound measured 8.2 cm x 8 cm, with a depth of 1.4 cm. The wound base was 90% granulation and 10% slough. There was a mild odor after the wound was cleansed. A Progress Note, dated 12/09/24, indicated there was a new physician's order to obtain a wound culture. The Lab Results Report for the wound culture ordered on 12/09/24 was reviewed. The sample was collected and received by the lab on 12/09/24. The results were reported on 12/16/24 and indicated there was heavy growth of Proteus Mirabilis bacteria and heavy growth of Beta Hemolytic Streptococci bacteria. The report listed the antibiotics that could be used to treat the bacteria. The lab results were reviewed by the Nurse Practitioner on 12/18/24. The report indicated The specimen was received without two patient identifiers on the specimen container. Clinical correlation confirming that the specimen was obtained from the named patient was recommended prior to action based on the results. The lab indicated they sent an affidavit related to the lack of resident identification information to the facility via fax on 12/10/24 with no response. The lab sent the affidavit a second time to the facility on [DATE] via fax. As of 12/16/24, there was no signed affidavit received. The sample may need to be recollected for testing due to missing identifier on specimen. During an interview, on 03/05/25 at 1:13 P.M., the Assistant Director of Nursing/Infection Preventionist indicated she reviewed the infection tracking every day. Every morning, she would review residents' physician's orders for lab tests that were ordered the previous day. She was unsure of what happened with the resident's wound culture order. During an interview, on 03/06/25 at 11:14 A.M., the Director of Nursing indicated typically, when the facility sent a sample out to the lab, they would get the results via fax. Cultures usually took 48 to 72 hours. The wound culture was sent out on 12/09/24, but they didn't get the results until 12/16/24. It should have been followed up on. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current facility policy titled GUIDELINES FOR LAB SCHEDULING/TRACKING, dated 09/01/23, indicated, .It is the policy of the facility to ensure that laboratory tests ordered by the physician are systematically scheduled and tracked so that lab work is obtained and results are received and reported timely .Any omitted labs will be researched and the lab will be contacted for an explanation as to the delay . 3.1-49(a)

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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. 34232 Based on observation and interview, the facility failed to follow appropriate infection control guidelines related to hand hygiene for 2 of 6 residents observed during medication administration. (Residents 52 and 7) Findings include: Medication administration was observed on Station 3 on 03/04/25 at 1:36 P.M., with Licensed Practical Nurse (LPN) 4. The nurse prepared a medication, Gabapentin 300 milligrams, at the medication cart in the hallway for Resident 3. The LPN took the medication into the resident's room in a medication cup. The resident had limited use of his hands, and the nurse assisted the resident by moving his straw. The resident's straw was in his personal water bottle. The LPN continued to assist the resident with adjusting his foot pedals and applying the brakes on his wheelchair. The nurse went back to the medication cart, picked up a medication cup, expelled a dose of Carbidopa/Levodopa into a cup for Resident 52, poured water into a plastic cup, put a straw into the cup, closed the medication cart, and locked it. While administering the medication to Resident 52, the nurse touched the resident's shoulder with her hand and assisted the resident with her medication. The nurse disposed of the water cup and medication cup at a sink near the dining room, went to the computer on the medication cart, touched the keys on the computer, went into Resident 7's room, touched the lift harness that was underneath the resident, then the nurse pulled up her own pants, and went back to the computer on the medication cart. During an interview, immediately following the observation on 03/04/25, LPN 4 indicated she should have used hand sanitizer or washed her hands between assisting the residents. The current MEDICATION ADMINISTRATION policy, dated July 2024, was provided by the DON on 03/05/25 at 3:04 P.M. The policy indicated, .Before the Medication Pass .Cleanse your hands before beginning and before contact with each resident . 3.1-18(l)