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	03/26/2026

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to act promptly regarding residents' concerns voiced during the Resident Council meetings for 4 of 12 months of meeting minutes reviewed. (August, September, October, and December 2025) Findings include:During the Resident Council Meeting, on 03/24/2026 at 1:45 P.M., the residents indicated the call lights were not answered in a timely manner and sometimes it took up to an hour to get assistance. The Resident Council Meeting Minutes were reviewed and indicated issues related to call lights were concerns on the following months: -August 2025, Residents indicated nursing staff were sitting in the office discussing personal things instead of coming to help answer call lights when needed. On Station 3 it was taking 45 minutes to an hour to answer call lights, -September 2025, Residents indicated they felt the Certified Nurse Aides (CNAs) sat in the nurse's station, didn't respond to the call lights, were forgetting to come back, and were told the CNAs didn't have time, -October 2025, Residents indicated one resident had to go to the bathroom at 11:30 P.M. At 12:30 P.M., still no one had come to help. Another resident had waited for 25 minutes for help. Another resident had waited for someone to change her, she couldn't stay in a Diaper due to wound care, and -December 2025, Residents indicated staff were not responding to call lights in a timely manner and residents were waiting longer than 15 minutes to get assistance. During an interview, on 03/24/2026 at 2:53 P.M., the Activity Director, who assisted the residents with the Resident Council meetings, indicated she typed up the concerns voiced by the residents at the meetings, then she distributed the concerns to each department. The paper given to each department was called a Resident Council Action Form. Then, she attached the completed action forms to the Resident Council Meeting Minutes the issues were brought up in for each month. During an interview, on 03/26/2026 at 9:44 A.M., the Regional Director of Operations indicated the concern forms were completed following a Resident Council Meeting, distributed to the identified departments, the response was documented on the forms, the forms were then placed with the Resident Council Meeting Minutes record to be reviewed with the residents at the next meeting. There were no Resident Council Action Forms completed for the August, September, October, or December 2025, Resident Council Meetings indicating the residents' concerns were addressed. The current GUIDELINES FOR RESIDENT COUNCIL policy, dated 06/20/2023, was provided by the Administrator on 03/24/2026 at 3:39 P.M. The policy indicated, .Residents have the right to be involved in making decisions that affect their lives .Group Concerns and Follow-Up .The council group members who voice a concern usually expect a timely response about the resolution to their concern. This must happen. The Administrator monitors this process .A concern is any issue identified by the group that requires a response from the facility in the form of a resolution to some degree that satisfies the group with an explanation and comment . 410 IAC (Indiana Administrative Code) 16.2-3.1-3(l)

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 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. Based on observation and interview, the facility failed to store medications appropriately for 3 of 5 medication carts observed. (Upstairs Medication Cart 3-2, Upstairs Medication Cart 3-1, and the Dementia Unit Medication Cart)Findings include:During an initial tour observation, on 03/22/2026 at 9:51 A.M., the Upstairs Medications Cart 3-2 was sitting in the hallway outside the nurse's station, unlocked, and unattended. Three staff members walked by the unlocked medication cart. At 9:52 A.M., a staff member walked by the cart and locked it. Upstairs Medication Cart 3-2 was observed with RN 11 on 03/22/2026 at 9:58 A.M., and contained the following in the bottom of the medication cart drawers:-One loose round tan pill, - One loose oval tan pill,- One small white pill, and - One oval green pill.At the time of the observation RN 11 indicated two of the pills in the bottom of the medication cart were Protonix and Eliquis. Upstairs Medication Cart 3-1 was observed with Qualified Medication Aide (QMA) 12 on 03/22/2026 at 10:00 A.M., and contained the following:- An unopened and undated Novolog insulin pen for Resident 70, was in the top drawer - An opened vial of Novolog for Resident 2 that had approximately 1/4 of the solution removed with an open date of 02/11/2026 and expiration date of 03/11/2026, was in the top drawer, and- Several crumbs and paper debris were scattered throughout the drawers.At the time of the observation QMA 12 indicated insulin was good for 28 days once it was opened. The Dementia Unit Medication Cart was observed with Licensed Practical Nurse (LPN) 13 on 03/22/2026 at 10:15 A.M., and contained the following:- An unopened and undated Lantus insulin pen for Resident 72, in the top drawer- Two loose round white pills, in a drawer- One loose round tan pill, in a drawer, and - One 1/2 white pill, in a drawer. The nurse indicated she was unsure what the pills were or who was responsible for cleaning the medication carts. She did attempt to clean the cart when she had time. During a continuous observation on 03/22/2026 from 10:49 A.M. through 11:11 A.M., the following was observed:-At 10:49 A.M., the medication cart was sitting in the locked unit outside of the nurse's station, in the common area. The medication cart was unlocked. A nurse was sitting in the nurse's station behind a locked door with her back to the cart, there were residents and nursing staff in the common area, - At 10:52 A.M., a staff member walked by the unlocked medication cart, - At 10:54 A.M., the Maintenance Director and a family member walked by the unlocked medication cart, - At 10:56 A.M., the Maintenance Director walk by the unlocked medication cart, there were also four residents sitting in the common area, - At 10:57 A.M., nursing staff staff members walked by the unlocked medication cart, - At 11:02 A.M., a housekeeper went to the unlocked medication cart and removed the trash on the side of the cart, the nurse was still behind the nurse's station with her back to the cart, - At 11:08 A.M., more nursing staff went behind the nurse's station, walking beside the unlocked medication cart, there were also four residents sitting in the common area where the cart was located, - At 11:09 A.M., two nursing staff members came out of the nurse's station, walked past the unlocked medication cart, and left the unit, - At 11:11 A.M., LPN 10 walked out the nurse's station and locked the medication cart. During medication administration pass, QMA 14 prepared medications for Resident 36. She left the medication cart in the hallway, unlocked and went to the resident's room. The medication cart was not visible from the resident's room. There were no residents or staff in the hallway and remained unlocked and unattended for less than two minutes. During an interview, on 03/25/2026 at 10:34 A.M., LPN 10 indicated medication carts should be locked or remain locked anytime the nurse walked away from the cart. During an interview, on 03/25/2026 at 12:42 P.M., the DON indicated medication carts should be locked if the nurse was not present. The current facility policy titled, Medication Storage in the Facility, dated February 2017, was provided by the Director of Nursing on 03/25/2026 at 1:10 P.M. The policy indicated, .Medications and biologicals are stored safety, securely, and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Medication rooms, carts, and medication supplies are locked or attended by person with authorized access.Medications requiring refrigeration or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in a refrigerator. Medications requiring storage ?in a cool place' are refrigerated unless otherwise directed on the label.Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists.Medication storage areas are kept clean, well lit, and free of clutter.the facility is required to keep the carts clean. A Novolog insert was provided by the DON on 03/25/2026 at 2:56 P.M. The insert indicated, .Unpunctured Novolog FlexPen or Novolog FlexTouch and PenFill cartridges can be used until the expiration date printed on the label if they are stored in the refrigerator. A Lantus insert was provided by the DON on 03/25/2026 at 2:56 P.M. The insert indicated, .Storage.single-patient-use SoloStar prefilled pen.Not in-use (unopened) Refrigerated.until expiration date. Not in-use (unopened) Room Temperature.28 days. 410 IAC (Indiana Administrative Code) 16.2-3.1-25(o)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop a resident's care plan related to the resident's leg prosthesis for 1 of 18 residents reviewed for care plans. (Resident 3)Findings include:Resident 3 was observed in his room on 03/22/2026 at 10:58 A.M. The resident was sitting in his wheelchair. The resident had an above the knee amputation of his left leg, his prosthetic leg was leaning against his bed. During an observation, on 03/23/2026 at 11:18 A.M., the resident was sitting in his wheelchair, he indicated there was something wrong with his prosthetic leg. The prosthesis was leaning against the side of his bed. He indicated he used to wear the prosthetic leg. During an interview, on 03/25/2026 at 11:12 A.M., Licensed Practical Nurse (LPN) 10 indicated Resident 3 did wear his prosthetic leg sometimes. During an interview, on 03/25/2026 at 1:52 P.M., Certified Nurse Aide (CNA) 3 indicated Resident 3 used to wear his prosthetic leg daily and occasionally needed staff assistance with putting it on and taking it off. During an interview, on 03/25/2026 at 2:20 P.M., the Therapy Manager indicated the resident participated in therapy from 12/10/2025 to 02/11/2026. During that time, he wore his prosthetic leg. Interview for Care plan tag at Waters of Dillsboro The clinical record for Resident 3 was reviewed on 03/23/2026 at 1:50 P.M. An admission Minimum Data Set (MDS) assessment, dated 12/15/2025, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, hypertension (high blood pressure), diabetes (metabolic disease characterized by high blood glucose due to the body's inability to produce enough insulin or effectively use the insulin), and acquired absence of the left leg. There was no indication the resident had a limb prosthesis. The resident admitted to the facility on [DATE]. The resident's Care Plans were reviewed on 03/23/2026 at 1:55 P.M. The resident's Care Plan lacked a plan of care related to the resident's care and interventions related to the resident's prosthetic leg. During an interview, on 03/26/2026 at 9:18 A.M., the MDS Coordinator indicated she started baseline and admission care plans. She would update the care plans based on any new orders or assessments of the resident. There should have been a care plan for the resident's prosthetic leg. The current facility policy, titled Baseline Care Plan Assessment/Comprehensive Care Plans, with a revision date of 03/23/21, was provided by the Director of Nursing (DON) on 03/25/2026 at 2:40 P.M. The policy indicated, .The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition 410 IAC (Indiana Administrative Code) 16.2-3.1-35(b)(1)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and record review, the facility failed to ensure a resident with a visual impairment received optical services in a timely manner for 1 of 1 resident reviewed for vision. (Resident 33) Findings include:Resident 33 was observed on 03/23/2206 at 11:25 A.M., sitting in her wheelchair in her room. An activity calendar was posted on her wall, and a monthly meal menu was sitting on her bedside table. There were no eyeglasses observed in the resident's room. During an interview, on 03/23/2026 at 11:29 A.M., Resident 33 indicated she had cataract removal surgery some time ago, but she still needed eyeglasses to read. She had an appointment with the eye doctor, but he referred her to a specialist. She went to the specialist, and he referred her back to the regular eye doctor. She kind of got the runaround and did not know what was happening with getting eyeglasses. She enjoyed coloring and reading, but she needed readers. The resident's record was reviewed on 03/23/2026 at 2:16 P.M. A document, scanned into the resident's Electronic Health Record (EHR), indicated the resident visited the ophthalmologist's office on 01/16/2026. The document was a prescription for the resident's eyeglasses. During an interview, on 03/24/2026 at 2:37 P.M., the Social Services Director (SSD) indicated a company routinely came to the facility and provided ancillary services that included dental, vision, and podiatry services. Usually, when the eye doctor examined a resident in the facility, they would write a prescription for eyeglasses, if needed. The eyeglasses would be ordered and sent to the facility within a few weeks. She would deliver the eyeglasses to the residents. She reviewed the records and indicated there was a prescription for eyeglasses in the resident's chart dated 01/16/2026. She reviewed the transportation logs and indicated that the resident did go out to an eye doctor appointment on 01/16/2026. She was not sure why the prescription was uploaded to the resident's EHR but was not followed up on. During an interview, on 03/24/2026 at 3:27 P.M., the SSD indicated the resident had been seen in the facility by the eye doctor and they had referred her to an ophthalmologist. She came back from that appointment with a prescription for eyeglasses. It probably should have been followed up on sooner. The current, undated facility policy, titled Vision and hearing services was provided by the Regional Nurse Consultant on 03/26/2026 at 10:41 A.M. The policy indicated, .It is the standard of the organization to ensure that residents receive the proper treatment and assistive devices to maintain hearing and vision abilities . 410 IAC (Indiana Administrative Code) 16.2-3.1-39(a)(1)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to urinary catheters for 2 of 3 residents reviewed for Urinary Tract Infections (UTI). (Residents 4 and 52)Findings include:1.During an observation, on 03/22/2026 at 10:15 A.M., Resident 4 was sitting in a recliner in the common area of the dementia unit. The resident's feet were propped up, and his urinary catheter drainage bag with a dignity flap, was lying on the floor. There was no dignity bag covering the urinary catheter bag. During an observation, on 03/24/2026 at 2:59 P.M., Resident 4 was sitting in a recliner in the common area of the dementia unit. The resident's urinary catheter drainage bag with a dignity flap, was touching the floor. There was no dignity bag covering the urinary catheter bag. During an observation, on 03/24/2026 at 3:15 P.M., Resident 4 was sitting in a recliner in the common area of the dementia unit. Approximately four to five inches of the resident's urinary catheter drainage bag with a dignity flap, was touching the floor. There was no dignity bag covering the urinary catheter bag. During an interview, on 03/24/2026 at 3:19 P.M., Licensed Practical Nurse (LPN) 5 indicated residents' urinary catheter drainage bags should not be touching the floor. The clinical record for Resident 4 was reviewed on 03/23/2026 at 2:52 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/09/2026, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, neurogenic bladder (a dysfunction of the lower urinary tract caused by damage to the nerves and muscles controlling bladder emptying). The resident had an indwelling urinary catheter. The resident used a wheelchair and was dependent on staff for care. A Progress Note, dated 02/13/2026 at 10:39 A.M., indicated the resident had new orders for an antibiotic for a UTI. A Progress Note, dated 03/19/2026 at 12:37 P.M., indicated the resident had a new physician's order to obtain a urine sample related to a foul-smelling odor. A Progress Note, dated 03/20/2026 at 2:09 P.M., indicated the Nurse Practitioner ordered to discontinue the residents Keflex (an antibiotic medication) and start Cefdinir 300 milligrams (mg), twice a day, for a UTI and cellulitis. 2. During an interview and observation, on 03/23/2026 at 10:23 A.M., Resident 52 was sitting in her room in her wheelchair. She indicated she had a urinary tract infection recently. Her urinary catheter drainage bag, with a dignity flap, was hanging under her wheelchair with approximately two inches of the bag touching the floor. There was no dignity bag covering the urinary catheter bag. During an observation, on 03/23/2026 at 10:57 A.M., Resident 52 was sitting in the dining room with approximately one inch of her urinary catheter drainage bag, with a dignity flap, touching the floor. There was no dignity bag covering the urinary catheter bag. During an observation, on 03/23/2026 at 1:05 P.M., Resident 52 was sitting in the dining room. Her urinary catheter drainage bag, with a dignity flap, was touching the floor. There was no dignity bag covering the urinary catheter bag. During an observation, on 03/24/2026 at 9:03 A.M., Resident 52 was sitting in the dining room. Three to four inches of the resident's urinary catheter drainage bag, with a dignity flap, was touching the floor. there was no dignity bag covering the urinary catheter bag. During an interview, on 03/24/2026 at 9:13 A.M., Qualified Medication Aide (QMA) 9 indicated residents' urinary catheter drainage bags should not touch the floor. During an observation and interview, on 03/24/2026 at 9:15 A.M., the Assistant Director of Nursing (ADON) indicated the resident's urinary catheter drainage bag should not touch the floor and that she would fix it at that time. The clinical record for Resident 52 was reviewed on 03/24/2026 at 2:55 P.M. The resident had an impairment to the upper and lower extremities and was dependent on staff for care. A Progress Note, dated 02/27/2026 at 6:52 P.M., indicated a new order was received for IM Ertapenem related to a UTI. The current facility policy titled, GUIDELINS FOR INDWELLING FOLEY CATHETER CARE dated 10/16/2024, was provided by the ADON on 03/24/2026 at 9:37 A.M. The policy indicated, .The main purpose of proper indwelling foley catheter care is to prevent catheter associated urinary tract infections. 410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(2)

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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. Based on interview and record review, the facility failed to ensure a newly admitted resident's weight was obtained as ordered and address a significant weight gain for 1 of 2 residents reviewed for nutrition. (Resident 11)Findings include:Resident 11's clinical record was reviewed on 03/23/2026 at 1:49 P.M. An admission Minimum Data Set (MDS) assessment, dated 03/03/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure, hypertension, and morbid obesity. The nutrition section of the assessment indicated the resident had not experienced a weight loss or weight gain of 5% or more in the last month or a weight loss or weight gain of 10% or more in last 6 months. The resident was 5' 3" and weighed 365 pounds (lbs.). The resident's current physician's orders included an open-ended order, with a start date of 03/01/2026 to obtain the resident's weight once a week on Sundays. The March Electronic Medication Administration Record (EMAR) indicated the following:- On 03/01/2026, the resident's weight was 365 lbs.,- On 03/08/2026, the resident's weight was not obtained,- On 03/15/2026, the resident's weight was 389 lbs., and- On 03/22/2026, the resident's weight was 393 lbs. During an interview, on 03/24/2026 at 3:38 P.M., the Director of Nursing (DON) indicated all newly admitted residents were reviewed in SWAT (Skin and Weight Assessment Team) meetings each week for the first four weeks the resident was in the facility, and then longer if needed. The meetings were held on Thursdays, and the Registered Dietician participated through video conferencing and completed the assessment. The DON was unaware of the resident's 24 lb. weight gain between 03/01/2026 and 03/15/2026. A SWAT assessment, dated 03/06/2026, indicated the resident was on weekly weights. The comments section of the assessment indicated the resident's weight was up 5 lbs. since admission and to monitor for further changes. Lab tests obtained on 02/25/2026 indicated high cholesterol and triglycerides and low red blood cells and low hemoglobin and hematocrit levels. The resident was not receiving any nutritional supplementation. They would continue the current plan of care and continue to monitor the resident weekly on SWAT. A SWAT assessment, dated 03/14/2026, indicated the resident was on weekly weights. The comments section in the assessment indicated the resident needed an updated weekly weight. The resident's Electronic Health Record (EHR) lacked any further SWAT assessments and lacked documentation that indicated the resident refused to be weighed. During an interview, on 03/24/2026 at 3:42 P.M., the DON indicated the resident's weight should have been obtained weekly as ordered and the significant weight gain should have been addressed. The current facility policy, titled GUIDELINES FOR OBTAINING RESIDENTS' WEIGHTS, and dated 07/24/2023, was provided by the DON on 03/25/2026 at 11:43 A.M. The policy indicated, .Weight is an indicator of nutritional and health status and changes in weight can often indicate other medical changes.Compare the obtained to the previous weight. If there is a significant variance (Ex: 5 lbs. more or less), be sure to reweigh the resident to verify the weight.If a weight is found to be incorrect-note this and initial the error-then notify the nurse for guidance.Weekly weights mean WEEKLY month to month-record and then report to physician per physician order and/or policy. The current, undated facility policy, titled S.W.A.T. PROGRAM (SKIN AND WEIGHT ASSESSMENT TEAM, was provided by the DON on 03/25/2026 at 11:43 A.M. The policy indicated, .It is the policy of this facility to assess the nutritional status of each resident. SWAT is designed to aggressively review and address those residents exhibiting significant weight change or skin breakdown. These residents will be monitored through this team effort on a weekly basis, involving all applicable disciplines to best cater to the improvement of the resident's nutritional status.Indicators determining implementation of SWAT monitoring.new admission.SWAT will meet weekly. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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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 have medications available for a resident for 1 of 18 residents reviewed for pharmacy services. (Resident 4)Findings include:The clinical record for Resident 4 was reviewed on 03/23/2026 at 2:52 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/09/2026, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to Alzheimer's disease (a progressive, incurable neurodegenerative disorder and the most common cause of dementia) and anxiety. The current, open-ended physician's order, with a start date of 02/24/2026, indicated the resident was to be administered Risperdal (an antipsychotic medication) 2 milliliters (ml) intramuscularly, every 14 days for delusions. The February and March 2026 Electronic Medication Administration Record (EMAR) indicated the resident had not received the medication on 02/24/2026 and 03/24/2026. A Progress Note, dated 02/24/2026 at 11:05 A.M., indicated the resident had not received the Risperdal medication due to the medication not being available at the pharmacy. A Progress Note, dated 03/24/2026 at 9:50 A.M., indicated the resident had not received the Risperdal medication due to the medication not being in the facility. The clinical record lacked documentation indicating the physician was notified of the resident not receiving the medications on 02/24/2026 and 03/24/2026. The Emergency Drug Kit (EDK) list was reviewed on 03/25/2026 at 10:37 A.M., the list excluded Risperdal injectable medications. During an interview, on 03/25/2026 at 10:34 A.M., Licensed Practical Nurse (LPN) 10 indicated if a resident didn't have medications available to be given, then she would check their EDK. If the medications were not available there, then she would call the pharmacy to see if it could be sent as soon as possible from a local pharmacy. If they couldn't get it from a local pharmacy, she would have the facility pharmacy get it to the facility as fast as they could. In the EMAR she would mark that the medication was not available and call the physician. She would document it in a progress note. During an interview, on 03/25/2026 at 12:42 P.M., the Director of Nursing (DON) indicated if medications were not available for residents, the staff were the check the EDK. If they were not available in the EDK, then they needed to get it ordered from the pharmacy. If a resident missed a dose of medication, then the provider would be notified. They typically would just verbally let the provider know and didn't document in the clinical record. The current facility policy tilted, Out of Stock Medications, dated July 2024, was provided by the DON on 03/25/2026 at 1:11 A.M. The policy indicated, .will maintain an inventory of medications available to meet resident's needs. In the event the facility orders a medication that the pharmacy does not currently stock:. Alternative suppliers will be contacted to check availability and expected date and time of delivery. The facility should call the patient's physician to let him/her know that the ordered medication is not available. The physician can then decide whether to hold the medication until it is available or change the medication to one that is readily available in the emergency dispensing kit. The original medication that was ordered will be sent as soon as it becomes available. If the resident requires the medication sooner.other area pharmacy sources will be contacted to supply the item. 410 IAC (Indiana Administrative Code) 16.2-3.1-25(a)

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	03/26/2026

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 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 interview and record review, the facility failed to maintain complete and accurate resident records related to medication administration for 1 of 18 residents reviewed for medical records. (Resident 36)Findings include:Resident 36's record was reviewed on 03/23/2026 at 2:11 P.M. An admission Minimum Data Set (MDS) assessment, dated 01/02/2026, indicated the resident's diagnosis included, but was not limited to, diabetes (a chronic metabolic disease characterized by high blood glucose due to the body's inability to produce enough insulin or effectively use the insulin it makes).The resident's physician's orders included, but were not limited to, a current, open-ended order, with a start date of 01/15/2026, for Lantus (a long-acting insulin). The resident was to receive 10 units every morning (between 8:00 A.M. and 10:00 A.M.) and at bedtime (between 8:00 P.M. and 10:00 P.M.) for diabetes. The resident's February and March 2026 Electronic Medication Administration Records (EMARs) were reviewed and there were blank spaces that indicated the resident did not receive the medication on the following dates and times:- On 02/01/2026 the EMAR lacked documentation the resident received the bedtime dose,- On 02/04/2026 the EMAR lacked documentation the resident received the bedtime dose,- On 02/08/2026 the EMAR lacked documentation the resident received the bedtime dose,- On 02/11/2026 the EMAR lacked documentation the resident received the bedtime dose,- On 02/15/2026 the EMAR lacked documentation the resident received the bedtime dose,- On 02/16/2026 the EMAR lacked documentation the resident received the bedtime dose,- On 02/26/2026 the EMAR lacked documentation the resident received the morning dose,- On 03/03/2026 the EMAR lacked documentation the resident received the bedtime dose,- On 03/13/2026 the EMAR lacked documentation the resident received the bedtime dose, and- On 03/22/2026 the EMAR lacked documentation the resident received the bedtime dose. During an interview, on 03/25/2026 at 1:54 P.M., RN 8 indicated there should not be blanks in the EMAR. When the medications were administered they should have been documented as given. If a medication was not administered, the nurse should indicate the medication was not given and document the reason why. The resident's progress notes were reviewed and lacked documentation related to the medication that was not documented as administered. The current facility policy, titled, Medication Administration, dated February 2017, was provided by the Director of Nursing on 03/25/2026 at 2:29 P.M. The policy indicated .Circle initials on MAR if medication is not administered as ordered and record reason in the PRN/Omission Medication section of the MAR . 410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(2)

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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 interview, observation, and record review, the facility failed to follow appropriate infection control guidelines for a resident with indwelling devices and for a resident during medication administration for 2 of 20 residents reviewed for infection control. (Residents 6 and 7)Findings include:1a.During an interview, on 03/22/2026 at 10:35 A.M., Resident 6 gave permission to observe care related to her indwelling urinary catheter. During an observation, on 03/23/2026 at 1:07 P.M., Resident 6 was in her room in bed. Approximately three inches of her indwelling urinary catheter bag was touching the floor. There was no clean barrier between the bag and the floor. During an observation, on 03/23/2026 at 2:26 P.M., Resident 6 was in her room in bed. Approximately three inches of her indwelling urinary catheter bag was touching the floor. There was no clean barrier between the bag and the floor. The clinical record for Resident 6 was reviewed on 03/23/2026 at 1:15 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/11/2026, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, renal insufficiency and neurogenic bladder. The resident had an indwelling urinary catheter and was always incontinent of bowel. The resident had a feeding tube while residing in the facility. Incontinence care for Resident 6 was observed on 03/25/2026 at 9:29 A.M., with Qualified Medication Aide (QMA) 2 and Certified Nurse Aide (CNA) 3. The two staff members entered the resident's room, explained the process to the resident, prepared garbage bags for the soiled items, and donned gloves. The CNA prepared wash clothes and laid them on the over bed table. The two staff members uncovered the resident who was lying in bed. The resident's indwelling urinary catheter tubing was anchored to her right thigh. The staff members rolled the resident and removed the feces soiled brief and placed it in a garbage bag. The CNA cleaned the feces off the resident's backside and placed the soiled washcloths in the garbage bag. The staff members rolled the resident onto her back, and the CNA cleaned feces from the front periarea (private area) turning the washcloth, then, using the same washcloth, cleaned the indwelling catheter tubing. The two staff members changed gloves, the QMA applied ointment to the resident's front private area, then they applied a clean brief. The QMA emptied the urine from the catheter drainage bag and hung the bag on the side of the resident's bed that was against the wall. The staff members assisted the resident with her pants, covered her with a blanket, pushed the bed against the wall, and lowered the bed. The staff members gathered the trash and soiled linens, washed their hands, and exited the room. The staff members did not don gowns prior to providing care and six to eight inches of the urinary catheter bag were left lying against the floor following care. The resident's room door had a sign on the outside indicating the resident was in Enhanced Barrier Precautions (EBP) and the staff were to don a gown and gloves prior to providing care. During an interview, on 03/25/2026 at 9:42 A.M., QMA 2 indicated, with the resident's bed against the wall, she wasn't sure how she would know if the resident's catheter bag was on the floor. The catheter bag should not be touching the floor. During an interview, on 03/25/2026 at 9:43 A.M., with QMA 2 and CNA 3, they indicated, when providing incontinence care, they usually started with the front of the private area, but the resident's bowel movements were usually runny, so they cleaned the back first. When going from the back of the private area to the front, you should change your gloves. During an interview, on 03/25/2026 at 9:59 A.M., CNA 3 indicated, for a resident in EBP, they should have worn a gown and gloves when providing care to the resident. 1b.Gastrostomy tube (G-tube) care for Resident 6 was observed with Licensed Practical Nurse (LPN) 4 on 03/25/2026 at 9:50 A.M. The LPN entered the resident's room, raised the bed, placed gloves, a small bottle of liquid, and gauze packages on the over bed table. The nurse washed her hands, donned gloves, and pulled the resident's blanket down to reveal the G-tube apparatus on the resident's stomach. There was no dressing on the G-tube site. The nurse opened the bottle of liquid, soaked gauze pads with the liquid, and cleaned around the entry site to the abdomen. A moderate amount of dried blood was noted on the gauze pads. The nurse applied a split gauze pad to the G-tube site against the resident's skin, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed her gloves, and applied tape to the gauze dressing. The nurse bagged the trash, ruffled through the drawers in a small cart in the resident's room, then washed her hands. The nurse lowered the bed. During an interview, on 03/25/2026 at 9:58 A.M., LPN 4 indicated she should have worn a gown when providing care since the resident was in EBP. During an observation, with the Infection Preventionist (IP), on 03/25/2026 at 10:05 A.M., Resident 6's bed was pushed up against the wall. Her indwelling urinary catheter bag had several inches of the bag laying on the floor by the wall. The IP donned gloves moved the catheter bag up higher on the side of the resident's bed, then raised the bed up to ensure the bag was no longer touching the floor. The IP indicated the bag should not be touching the floor and staff were educated often regarding indwelling urinary catheter care. The resident had not had an infection involving her G-tube. The Enhanced Barrier Precautions STOP sign, posted on the outside of the resident's room door, indicated staff must, .Wear gloves and a gown for the following High-Contact Resident Care Activities .Providing Hygiene .Device care or use .urinary catheter, feeding tube . 2. During an observation, on 03/23/2026 at 11:08 A.M., LPN 5 was preparing medications for Resident 7. With her bare hands, the nurse unlocked the medication cart, pulled open the narcotic drawer, unlocked the narcotic drawer, popped two pills into her bare hands, and dropped them in a medication cup. She then administered the medications to the resident. During an interview, on 03/25/2026 at 2:41 P.M., the IP indicated staff should not touch resident medications with their bare hands during medication administration. The current facility policy titled, Medication Administration dated February 2017, was provided by the Director of Nursing on 03/25/2026 at 2:29 P.M. The policy indicated, .To administer all medications safely and appropriately. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)(2)