STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Indianapolis, The	3895 S Keystone Ave Indianapolis, IN 46227

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44849 Based on interview and record review, the facility failed to ensure resident rights were maintained when a cognitively intact resident was not allowed to sign out for a leave of absence for 1 of 3 residents reviewed for resident's rights. (Resident C) Findings include: During an interview on 2/6/25 at 9:42 a.m., Resident C indicated the staff had told her that she cannot sign out and leave the facility for a leave of absence and they had not let her leave. During an interview on 2/6/25 at 1:09 p.m., the Director of Nursing (DON) indicated Resident C was allowed to sign out and leave the facility with family or friends, but not with her boyfriend. Resident C was not allowed to sign out on her own even though she was cognitively intact. The DON did not think Resident C's rights were violated. The clinical record was reviewed on 2/7/25 at 12:13 p.m. The diagnoses included, but were not limited to, alcohol abuse, psychoactive substance abuse, and bipolar disorder. An Admission Minimum Data Set (MDS) assessment, dated 12/25/24, indicated Resident C was cognitively intact. A current physician's order, dated 12/24/24, indicated Resident C may not go out on a leave of absence. There was no stop date noted. On 2/6/25 at 11:44 a.m., the DON provided a copy of an undated facility policy, titled Your Rights and Protections as a Nursing Home Resident, and indicated this was the current policy used by the facility. A review of the policy indicated residents have the right to leave the facility. This citation relates to Complaint IN00451215. 3.1-3(a)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44849 Based on interview and record review, the facility failed to report an allegation of abuse for 1 of 3 residents reviewed for abuse. Staff did not immediately report to the administrator when staff overheard a female resident tell a male staff member she would report him for hitting her and did not accurately report all known information regarding the allegation of abuse at the time the allegation was reported to the state survey agency. (Resident B, CNA 1, CNA 2, DON, Floor Tech) Findings include: During an interview on 2/6/25 at 10:02 a.m., Resident B indicated a couple of weeks ago, in the morning, she was wheeling down the hall and attempted to pass the Floor Technician (Floor Tech), from behind, as he was buffing the floor. The machine was plugged in and the cord was across the floor, and Resident B was on his left. The Floor Tech stuck out his left arm and hit her right shoulder. Resident B said I'm telling that you hit me. Resident B didn't think the Floor Tech. intended to hit her. Resident B couldn't remember the date this happened, but thought it happened between 1/20/25 and 1/22/25. During an interview on 2/6/25 at 10:16 a.m., the Floor Tech indicated, on the morning of 1/22/25, he was buffing the floor when Resident B wheeled the front wheels of her wheelchair over the power cord to the buffer. He told Resident B to back off the cord and as the Floor Tech pulled the cord out of the wall he touched Resident B's hand. The Floor Tech left work until approximately 1:30 p.m., that day until the Director of Nursing (DON) told him he had to leave due to the abuse allegation. During an interview on 2/6/25 at 10:32 a.m., the Director of Nursing (DON) indicated on 1/22/25 at approximately 6:01 a.m., Resident B reported she was going down the hallway and tried to roll over the cord to the buffer as the Floor Tech was buffing the floor. Resident B said the Floor Tech jerked the cord out of the wall and purposely hit her right upper arm. The Floor Tech said he stuck his arm out, so Resident B didn't get hurt. CNA 1 and CNA 2 heard Resident B tell the floor tech she was going to report him for hitting her. The DON wasn't sure if all of that information should have been included in the initial incident report for the state health department because the corporate office had to approve it before they filed it. During an interview on 11:06 a.m., CNA 1 indicated she never heard Resident B tell anyone she would report them for hitting her. CNA 1 was not aware of any incident that occurred with Resident B and the Floor Tech. This was the first time CNA 1 heard anything about any incident between Resident B and the Floor Tech. During an interview on 2/6/25 at 1:24 p.m., CNA 2 indicated when she was standing in another residents bathroom getting ready to provide morning care when she heard Resident B say she was going to report that someone hit her. CNA 2 didn't leave the other resident's room to check on Resident B nor report what Resident B said. CNA 2 should have reported what Resident B said. The clinical record for Resident B was reviewed, on 2/6/25 at 11:32 a.m. The diagnoses included, but were not limited to, bacteremia, acute respiratory failure, and pulmonary edema (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission Minimum Data Set (MDS) assessment, dated 12/18/24, indicated Resident B was cognitively intact and used a wheelchair. On 2/6/25 at 11:42 a.m., the DON provided a copy of a typed document and indicated it was the statements from staff about Resident B's allegation. A review of the document indicated CNA 2 overheard Resident B say that she was going to report him for hitting her. On 2/6/25 at 11:44 a.m., the DON provided a copy of an undated facility policy, titled Abuse Prevention Program, and indicated this was the current policy used by the facility. A review of the policy indicated all employees must promptly report any incident or suspected incident of abuse. On 2/7/25 at 9:20 a.m., the DON provided the reportable incident, dated 1/22/25 at 6:01 a.m., indicated on 1/23/25 the Floor Tech reported to the Administrator that Resident B was going to report him when she tried to pass him this morning, on 1/22/25, as she was going to the pantry, and he was buffing the floors when she tried to pass him and roll her wheelchair over the cord. On 2/7/25 at 2:30 p.m., the facility was unable to provide a policy regarding reporting to the state health department. 3.1-28(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 44849 Based on interview and record review, the facility failed to follow the abuse policy and ensure an alleged perpetrator of abuse was immediately removed from the facility for 1 of 3 residents reviewed for abuse. (Resident B, Floor Tech, CNA 1, CNA 2) Findings include: During an interview on 2/6/25 at 10:02 a.m., Resident B indicated a couple of weeks ago, in the morning, she was wheeling down the hall and attempted to pass the Floor Technician (Floor Tech), from behind, as he was buffing the floor. The machine was plugged in, the cord was across the floor, and Resident B was on his left. The Floor Tech stuck out his left arm and hit her right shoulder. Resident B said I'm telling that you hit me. Resident B didn't think the Floor Tech intended to hit her. Resident B couldn't remember the date this happened, but thought it happened between 1/20/25 and 1/22/25. During an interview on 2/6/25 at 10:16 a.m., the Floor Tech indicated, on the morning of 1/22/25, he was buffing the floor when Resident B wheeled the front wheels of her wheelchair over the power cord to the buffer. He told Resident B to back off the cord and as the Floor Tech pulled the cord out of the wall he touched Resident B's hand. The Floor Tech left work at approximately 1:30 p.m., that day until the Director of Nursing (DON) told him he had to leave due to the abuse allegation. During an interview on 2/6/25 at 10:32 a.m., the Director of Nursing (DON) indicated CNA 1 and CNA 2 heard Resident B tell the floor tech she was going to report him for hitting her. During an interview 2/6/25 at 11:06 a.m., CNA 1 indicated she never heard Resident B tell anyone she would report them for hitting her. CNA 1 was not aware of any incident that occurred with Resident B and the Floor Tech. This was the first time CNA 1 heard anything about any incident between Resident B and the Floor Tech. During an interview on 2/6/25 at 1:24 p.m., CNA 2 indicated she was standing in another residents bathroom getting ready to provide morning care when she heard Resident B say Resident B was going to report that someone hit her. CNA 2 didn't leave the other resident's room to check on Resident B nor report what Resident B said. CNA 2 should have reported what Resident B said. The clinical record for Resident B was reviewed 2/7/25 at 11:32 a.m. The diagnoses included, but were not limited to, bacteremia, acute respiratory failure, and pulmonary edema An admission Minimum Data Set (MDS) assessment, dated 12/18/24, indicated Resident B was cognitively intact and used a wheelchair. On 2/6/25 at 11:42 a.m., the DON provided a copy of a typed document and indicated it was the statements from staff about Resident B's allegation. A review of the document indicated CNA 1 saw the Floor Tech. and Resident B but did not see an inappropriate interaction. CNA 1 overheard Resident B say she was going to report him for hitting her. CNA 2 did not see an inappropriate interaction but overheard Resident B say she was going to report him for hitting her. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/7/25 at 8:06 a.m., the DON indicated, on 1/22/25 at approximately 6:01 a.m. Resident B told the DON that earlier that morning she wheeled down the hallway and tried to roll over the cord to the buffer as the Floor Tech was buffing the floor. Resident B said the Floor Tech jerked the cord out of the wall and purposely hit her right upper arm. The DON wasn't sure if all of that information should have been included in the initial incident report for the state health department because the corporate office had to approve it before they filed it. During an interview on 2/7/25 at 8:50 a.m., the Administrator indicated the Floor Tech should have stopped and removed himself from the floor. CNA 2 should have stopped what she was doing and ensured Resident B's safety. The Floor Tech should have been removed from the facility at that time. On 2/6/25 at 11:44 a.m., the DON provided a copy of an undated policy, titled Abuse Prevention Program, and indicated this was the current policy used by the facility. A review of the policy indicated separate the alleged perpetrator and ensure all resident's safety. Staff members who are suspected of abuse shall immediately be barred from any further contact with residents and be suspended from duty. 3.1-28(d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 44849 Based on observation, interview, and record review, the facility failed to ensure medications were stored in accordance with accepted professional principles for 2 of 3 residents observed for medication administration. An unlabeled medication was not removed from the medication cart and eye drops were not dated when opened. (Resident D, QMA 1, LPN 1) 1. During a medication pass observation on 2/6/25 at 8:09 a.m., Qualified Medication Aide (QMA) 1 pulled a pill packet out of the medication cart. The packet had the label torn off so there was no resident name, no medication name or strength, and no instructions. Two white round pills with 54/24 on one side of each pill were observed. At that time, QMA 1 indicated the medication packet with the label removed should not have been left in the medication cart because she didn't know who the medication was for, what the medication was, nor the directions. During an interview on 2/6/25 at 10:32 a.m., the Director of Nursing (DON) indicated the medication packet with the label removed should have been removed from the medication cart. On 2/6/25 at 11:44 a.m., the DON provided a copy of a facility policy, titled Prescription Labels, dated 3/2023, and indicated this was the current policy used by the facility. A review of the policy indicated medication containers having damaged labels are returned to the pharmacy. 2. During a medication pass observation on 2/6/25 at 8:46 a.m., Licensed Practical Nurse (LPN) 1 removed the wrapper and opened a new bottle of Zaditor 0.035% eye drops (antihistamine eye drop used to treat itchy eyes) for Resident D. LPN 1 did not date the newly opened bottle before nor after the eye drops were administered. During an interview on 2/6/25 at 10:32 a.m., the Director of Nursing (DON) indicated the bottle of Zaditor eye drops should have been dated when the nurse opened it. On 2/7/25 at 2:30 p.m., the facility was unable to provide a policy regarding dating opened medications. This citation relates to Complaint IN00451215. 3.1-25(j)

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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. 44849 Based on observation, interview, and record review, the facility failed to ensure infection control was maintained during the administration of eye drops for 1 of 3 residents reviewed for medication administration. (Resident D, LPN 1) Findings include: During a medication pass observation on 2/6/25 at 8:46 a.m., Licensed Practical Nurse (LPN) 1 carried a bottle of Zaditor 0.035% eye drops (antihistamine eye drop used to treat itchy eyes) into Resident D's room. LPN 1 was not observed to be wearing gloves. LPN 1 explained what she was going to administer and took a pair of clean gloves out of a box and donned the gloves while holding the eye drops. LPN 1 was not observed to perform hand hygiene before donning the gloves. LPN 1 ensured Resident D was sitting up in his chair and leaned his head back, gently pulled down the lower right eye lid, and administered one drop into the outer edge of the right eye and applied pressure for three seconds. Then LPN 1 pulled the left lower eye lid down, administered one drop into the outer left eye and applied pressure for three seconds. LPN 1 asked Resident D if he was okay, removed her gloves, and left the room. No hand hygiene was observed. LPN 1 placed the bottle of eye drops back into the labeled baggy in the top drawer of the medication cart. During an interview on 2/6/25 at 10:32 a.m., the Director of Nursing (DON) indicated the nurse should have washed her hands before she put on gloves to administer Resident D's eye drops. On 2/6/25 at 11:44 a.m., the DON provided a copy of a facility policy, titled Eye Drop Administration, dated 3/2023, and indicated this was the current policy used by the facility. A review of the policy indicated properly wash hands before and after the administration of eye drops. This citation relates to Complaint IN00451215. 3.1-18(b)(1)