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	06/26/2025

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

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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 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. Based on observation, interview, and record review, the facility failed to ensure the person-centered comprehensive care plan was developed for 1 of 21 residents reviewed for care plans. The care plan was not developed for a resident who was at risk for falls and whose preference was to keep the bed in the high position. (Resident 42) Finding includes: On 6/22/25 at 10:22 a.m., Resident 42 was observed resting in bed. The bed was located next to the wall with the resident's right side near the wall. Resident 42's bed was observed to be in the highest position and was approximately 40 inches above the floor. The handheld bed control device was observed on the bed and within reach of the resident. No staff were visible in the area during that time. During an interview at that time, Resident 42 indicated she was able to adjust the height of the bed and she liked it in the highest position. On 6/22/25 at 12:33 p.m., Resident 42 was observed resting in bed while eating her noon meal. The bed was located next to the wall with the resident's right side near the wall. Resident 42's bed was observed to be in a high position and was approximately 35 inches above the floor. The handheld bed control device was observed on the bed and within reach of the resident. No staff were visible in the area during that time. On 6/22/25 at 1:41 p.m., Resident 42's clinical record was reviewed. The diagnoses included, but were not limited to, vascular dementia and hemiplegia and hemiparesis following a cerebral infarction (stroke with one-sided weakness or paralysis) affecting the right dominant side. The Quarterly Minimum Data Set (MDS) assessment, dated 6/16/25, indicated Resident 42 was severely cognitively impaired. The Fall Risk Review assessment, dated 6/13/25, indicated Resident 42 was at a high risk for falls. Resident 42's person-centered comprehensive care plan, dated 3/3/22, indicated Resident 42 was .at risk for falls related to right sided deficit . Resident 42's person-centered comprehensive care plan failed to address Resident 42's preference for keeping the bed in the high position. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/25 at 10:19 a.m., LPN 3 indicated Resident 42 had been educated multiple times on the safety concerns of having the bed in the highest position. For a while now, Resident 42 has continued to adjust the bed to the highest position. During an interview on 6/25/25 at 11:07 a.m., the Assistant Director of Nursing (ADON) indicated Resident 42's clinical record lacked a person-centered comprehensive care plan that addressed Resident 42's preference for keeping the bed in the high position. The ADON indicated Resident 42's care plan should have been developed. On 6/25/25 at 1:45 p.m., the Regional Nurse Consultant (RNC) provided a copy of the Baseline Care Plan Assessment/Comprehensive Care Plans policy, dated 3/23/21, and indicated it was the current policy in use by the facility. A review of the document indicated, .The Comprehensive Care Plans will be reviewed and updated .the facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues . 3.1-35(a)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. Based on record review and interview, the facility failed to ensure a medication was administered by qualified personnel for 1 of 19 residents reviewed for medication administration. (Resident B) Finding includes: On 6/24/25 at 1:00 p.m., the Director of Nursing (DON) provided a copy of a facility reportable incident, dated 5/26/25. The incident indicated on 5/26/25, Resident B reported to the facility that on 5/25/25, CNA 8 administered medication that Resident B believed was Tylenol. On 6/24/25 at 1:22 p.m., the Director of Nursing provided a copy of the facility investigation. The investigation included, but was not limited to: The Administrator's written statement, dated 5/26/25, indicated the Administrator had interviewed CNA 8. CNA 8 admitted giving Resident B pills. CNA 8 obtained the tylenol from behind the nurses station and gave them to the Resident B because he did not want the resident to have to wait for the nurse. An email from RN 10, dated 5/26/25, indicated RN 10 had worked on the night of the incident. Resident B was under her care that night. RN 10 was not aware that Resident B was having any pain that night and was unaware that CNA 8 had administered medication to the resident. During an interview on 6/24/25 at 1:33 p.m., Resident B indicated he had a headache on the night of 5/25/25 and turned on his call light to request pain medication. CNA 8 came in to the resident's room in response to the call light. Resident B informed CNA 8 he had a headache. The CNA explained to Resident B that he would get it. The CNA left the room and returned with 2 capsules that were red and gray in color. The resident took the capsules that the CNA brought to him. Resident B then indicated he started to worry and feel funny. The pills did not look like the tylenol he normally received. Resident B reported the incident to the nurse. The nurse called the physician and received orders to send the resident to the emergency room for evaluation and treatment. Resident B indicated the toxicology report from the hospital indicated the medication administered from the CNA was acetaminophen (tylenol). On 6/24/25 at 1:45 p.m., the clinical record of Resident B was reviewed. The diagnoses included, but were not limited to, pain in right knee, pain in left knee, and pain in lower back. An annual Minimum Data Set Assessment, dated 5/29/25, indicated Resident B was cognitively intact. A Physician's Order, dated 4/21/25, indicated Acetaminophen oral tablet 500 mg. Give one tablet by mouth every 4 hours as needed. On 6/24/25 at 1:00 p.m., the Director of Nursing provided a copy of the Certified Nursing Aides job description, dated 4/1/2023. The job description indicated, Position Summary: The Certified Nursing Assistant (CNA) provides each resident with routine daily nursing care and services in accordance with the resident's assessment and care plan with a passionate focus on customer service. Essential Job Functions: A. Role Responsibilities - Care: .Reports all changes in resident's condition to the Nurse Supervisor/ Charge Nurse immediately. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 10:47 a.m., the Regional Nurse Consultant provided a document titled Indiana State Department of Health Nurse Aide Curriculum, dated 11/19/15, and indicated it was the current practice of the facility to follow. The document indicated, The nurse aide will perform only the task in the course standards and Resident Care Procedure manual .The Nurse Aide will not administer any medications . This citation relates to Complaint IN00460186. 3.1-35(g)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the facility was free from accident hazards for 1 of 1 observation, potentially affecting 13 of 19 self-mobile cognitively impaired residents residing in the Memory Care Unit. An electrical cord was observed on the floor in the middle of a walkway area that was used by the residents. (Resident 29) Finding includes: During an observation of the Memory Care Unit on 6/23/25 from 9:00 a.m. to 9:10 a.m., the following was observed: - The Floor Technician was using an electric buffer/scrubber (buffer) machine on the floor space between rooms [ROOM NUMBERS]. The machine's yellow colored electric cord was approximately one inch in circumference and was approximately 20 feet in length. The cord was observed to be plugged into the hallway outlet located near room [ROOM NUMBER]. As the Floor Technician used the buffer machine, he was observed moving from one side of the hallway to the other side of the hallway as he made his way from room [ROOM NUMBER] toward room [ROOM NUMBER]. The machine's electric cord was observed lying in the middle of the hallway and at multiple points the cord was curled up against itself causing it to be raised above the floor approximately eight to ten inches. No caution signs were visible in the area. - Resident 29, who resided in room [ROOM NUMBER], was observed walking on the left side of the hallway, had stepped over the electric cord that was lying in the middle of the hall and then walked between the cord and the right side of the hall toward her room. As she approached the back of the Floor Technician, without turning or looking at the resident or the electric cord's location, the Floor Technician instructed Resident 29 to just step over the cord! Resident 29 was then observed raising her left foot and then her right foot approximately eight inches high as she stepped over the curled electric cord. - The Floor Technician continued using the buffer without adjusting or moving the electric cord from the middle of hall. - During an interview at that time, the Floor Technician indicated no posted caution sign was required to be visible while he used the buffer machine as the floor was not wet. He generally buffed one side of the hall and then buffed the other side of the hall. The machine's electric cord, approximately 20 feet in length, was to be kept near the wall as opposed to lying in the middle of the hallway because the Memory Care Unit had lots of residents who constantly walk the floors. - During an interview at that time, LPN 3 indicated the electric cord should not be left in the middle of the hall and a caution sign should have been posted in the area while the floor was being buffed. On 06/23/25 at 10:52 a.m., Resident 29's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS) assessment, dated 6/12/25, indicated Resident 29 was moderately cognitively impaired. A review Resident 29's Care Plan, dated 3/13/20, included, but was not limited to, .Resident was at risk of falls related to weakness and medications . On 6/24/25 at 10:03 a.m., the Administrator provided a copy of the resident list which indicated 13 of 19 residents residing on the memory care unit were cognitively impaired and self-mobile. During an interview on 6/23/25 at 1:45 p.m., the Regional Director of Operations indicated the facility did not have a policy for the prevention of accidents or potential hazards. 3.1-45(a)(1)

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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. Based on observation and interview, the facility failed to ensure a treatment cart was securely locked for 1 of 1 random observations. (Faith Hall Treatment Cart) Finding includes: On 6/22/25 from 8:15 a.m. to 8:30 a.m., observed a treatment cart on the Faith Hall to be unlocked and easily opened. No staff were observed in the area. Several residents were sitting in the hall in wheelchairs approximately 4 feet from the cart. The contents of the treatment cart, included but was not limited to: - multiple 0.5 oz tubes of Antifungal cream 2% (used to treat a skin fungus). The label indicated Keep out of reach - multiple 60 gram tubes of Fludocinonide cream 0.05% (used to treat inflammation of the skin). The label indicated Keep out of reach - multiple 1 ounce tubes of gentamicin cream 1%, (used to treat skin infections). The label indicated Keep out of reach. During an interview on 6/22/25 at 8:30 a.m., LPN 3 indicated the cart should have been locked. On 6/23/25 at 2:08 p.m., the Administrator provided a policy titled Medication Storage In The Facility, dated July 2024, and indicated it was the current policy being used by the facility. A review of the policy indicated . 3. Medication rooms, carts, and medication supplies are locked or attended by person with authorized access . 3.1-25(m)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure dietary staff's facial hair was covered to prevent exposure to food and drinks while in the kitchen for 1 of 2 observations. This had the potential to affect 63 of 63 residents residing in the facility who received food from the kitchen. (Dietary Aide 2) Finding includes: During a kitchen observation on 6/22/25 from 11:40 a.m. to 12:45 p.m., the following was observed: - Dietary Aide 2 was observed in the kitchen near the prepared foods that were uncovered on the steam table. Dietary Aide 2 was observed to have facial hair on his chin approximately one fourth inch in length and was observed scooping ice from the ice machine into glasses, pouring drinks from a pitcher to be served to the residents. Dietary Aide 2 was not observed to be wearing beard net. During an interview on 6/22/25 at 12:45 p.m., the Dietary Manager indicated that staff's hair should be covered when in kitchen. During an interview on 6/22/25 at 1:04 p.m., the Assistant Director of Nursing indicated that hair nets should be worn when around food or drinks. On 6/22/25 at 1:14 p.m., the Assistant Director of Nursing provided a copy of Food Safety & Sanitation, Policy: Employee Health & Personal Hygiene dated 4/2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, Policy # 2, Procedure . Hair restraints will be worn at all times. Beards should [be] well-trimmed and covered with an appropriate hair restraint, . On 6/22/25 at 2:00 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, (b)food employees shall wear hair restraints, such as hats, hair coverings or nets .that are designed and worn to effectively keep their hair from contacting .exposed food . 3.1-21(i)(2) 3.1-21(i)(3)

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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 and record review, the facility failed to implement infection control practices for 2 of 5 residents reviewed for immunizations. The two-step tuberculosis skin test series was not completed. (Resident 15, Resident 58) Findings include: 1. On 6/22/25 at 10:10 a.m., Resident 15's clinical record was reviewed. Resident 15's diagnoses included, but were not limited to, paraplegia (paralysis of the legs or lower body), bipolar disorder (a mental illness characterized by extreme shifts in mood, energy, and activity levels), and chronic osteomyelitis (an infection of the bone). Resident 15 had an admission date of 1/16/25. Resident 15's TB (tuberculosis) test administration history indicated that the resident had an order for a first step TB skin test to be administered 1/17/25 which had been coded on the EMAR (electronic medication administration record) as a 2, which indicated the resident refused the administration. The second step TB skin test ordered for 1/31/25 indicated other/see nurse note. Neither the first step or the second step TB skin test were documented as administered. Resident 15 had a TB screening tool assessment completed on 6/3/25. During an interview on 6/25/25 at 12:45 p.m., the RNC (Regional Nurse Consultant) and the DON (Director of Nursing) indicated that Resident 15 never received a first step or a second step TB skin test; Resident 15 had refused administration of all vaccines and the TB skin test. The RNC and the DON indicated that a resident who refused to have the two-step Mantoux skin test would have a chest x-ray and a TB screening tool assessment done. They each indicated the TB screening tool assessment should have been done at the time of admission or at the time of the resident's refusal to have the TB skin tests administered. 2. On 6/22/25 at 11:20 a.m., Resident 58's clinical record was reviewed. Resident 58's diagnoses included, but were not limited to, congestive heart failure (occurs when the heart doesn't pump enough blood to meet the body's needs), right lower extremity amputation above the knee, and kidney failure. Resident 58 had an admission date of 8/9/24. Resident 58's TB test administration history indicated no administration of a first or a second step TB skin test. Resident 58 had a TB screening tool assessment completed on 6/17/25. During an interview on 6/25/25 at 12:45 p.m., the RNC and the DON indicated that Resident 58 had not received a first step or a second step TB test, and that Resident 58 should have had them administered upon admission. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/25 at 11:25 a.m., the RNC provided a copy of a Clinical Policy and Procedure titled Tuberculosis Testing Policy and Procedure, dated 1/24/22, and indicated it was the policy currently in use by the facility. A review of the policy indicated, Facility will ensure that all Residents admitted from the community .have completed tuberculosis screening using the two-step method upon hire/admission . 3.1-18(b)(1)