STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Tipton Skilled Nursing Facility, The	300 Fairgrounds Rd Tipton, IN 46072

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a person-centered care plan was developed with individualized interventions and reviewed and revised to accommodate the resident's care needs prior to initiating a medication to control behaviors for 1 of 1 resident reviewed for dementia care. (Resident C)Findings include:The clinical record for Resident C was reviewed on 7/17/25 at 10:06 am. The diagnoses included, but were not limited to, dementia, cognitive communication deficit, and muscle weakness. A handwritten document, titled Behavior Sheet, dated 6/17/25, indicated Resident C had a sexually inappropriate behavior when he grabbed CNA 1's butt with both his hands. She was standing him up to move him to his wheelchair when he touched her. The CNA provided the resident with instructions or redirected him, which improved the behavior immediately.The handwritten note was provided after the start of the survey and was not located in Resident C's medical record. A handwritten document, titled Behavior Sheet, dated 6/21/25, indicated Resident C inappropriately physically touched CNA 2 during personal care. He tried to kiss the employee. He was redirected and the employee asked him to stop and the behavior gradually improved. The handwritten note was provided after the start of the survey and was not located in Resident C's medical record. A handwritten document, titled Behavior Sheet, dated 6/22/25, indicated Resident C was touching the inner thighs of CNA 3 inappropriately while she was checking and changing him. She provided instructions to him or redirected him, and his behavior improved gradually.The handwritten note was provided after the start of the survey and was not located in Resident C's medical record. A nursing progress note, dated 6/22/25 at 3:26 p.m., indicated Resident C was forgetful and confused. At times, he had to be redirected because he went into other residents' rooms and needed friendly reminders of where his room was located. A nursing progress note, dated 6/23/25 at 10:14 a.m., indicated Resident C needed reminders not to touch other residents.A nursing progress note, dated 6/23/25 at 3:19 p.m., indicated Resident C's physician saw the resident and wrote a new order for medroxyprogesterone (a synthetic progestin used in men primarily for treating abnormal sexual behaviors by reducing testosterone levels) 5 mg (milligram) by mouth every day. An initial psychiatry consultation note, dated 6/23/25, indicated the reason for the visit was to assess Resident C's mental illness and manage his medication. He had a history of depression and dementia and presented for an evaluation for increased sexual behaviors. He had been exhibiting increased sexual behaviors, including inappropriate touching of female staff and reports of masturbation in his room. He was not a danger to himself or others. He was having sexual aggression. His Brief Interview for Mental Status (BIMS) assessment, on 5/26/25, score was 10, which indicated a moderately cognitive impairment. He had a diagnosis of dementia with behavioral disturbance. Staff had reported he had increased sexual behaviors and masturbation which were new developments for this resident. Progesterone therapy at 5 mg daily was initiated to manage his sexual behavioral disturbances. A physician's order, dated 6/24/25, indicated to give medroxyprogesterone acetate 5 mg by mouth once a day for inappropriate sexual behaviors. A handwritten document, titled Behavior Sheet, dated 6/25/25, indicated Resident C was touching CNA 4 inappropriately. She provided instructions and/or redirection and used conflict resolution, and his behavior did not improve. The handwritten note was provided after the start of the survey and was not located in Resident C's medical record. A nursing progress note, dated 7/8/25 at 6:17 p.m., indicated the nurse was in the dining room prior to dinner attending to another resident. When she turned and looked out into the dining room, she observed Resident C had his outstretched hand patting Resident B's upper chest to lower shoulder area.A nursing progress note, dated 7/8/25 at 6:24 p.m., indicated Residents B and C were in the dining room and fully dressed. Resident C patted Resident B on the upper chest to lower shoulder area.A social service progress note, dated 7/10/25 at 10:02 a.m., indicated the psychiatric hospital had indicated the reason Resident C was not picked up and transported to their facility last evening was because they were calling his spouse, but was unable to receive consent from her to transfer him. The Social Service Director (SSD) and the Admissions Director called the spouse, and she gave her consent by phone for him to be transferred. The psychiatric hospital transported the resident that afternoon. The Electronic Medication Administration Record (EMAR), for June 2025, indicated Resident C received medroxyprogesterone acetate 5 mg on 6/24/25 through 6/30/25. The EMAR lacked documentation the resident was being monitored for inappropriate sexual behaviors.The EMAR, for July 2025, indicated Resident C received medroxyprogesterone acetate 5 mg on 7/1/25 through 7/10/25. The EMAR lacked documentation the resident was being monitored for inappropriate sexual behaviors. Resident C had a care

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure an assessment which included prior interventions, risks and benefits, and the clinical rationale for the initiation of a medication to control behaviors was completed and documented for 1 of 3 residents reviewed for unnecessary medications. (Resident C)Findings include:The clinical record for Resident C was reviewed on 7/17/25 at 10:06 am. The diagnoses included, but were not limited to, dementia, cognitive communication deficit, and muscle weakness. A handwritten document, titled Behavior Sheet, dated 6/17/25, indicated Resident C had a sexually inappropriate behavior when he grabbed CNA 1's butt with both his hands. She was standing him up to move him to his wheelchair when he touched her. The CNA provided the resident with instructions or redirected him, which improved the behavior immediately.The handwritten note was provided after the start of the survey and was not located in Resident C's medical record. A handwritten document, titled Behavior Sheet, dated 6/21/25, indicated Resident C inappropriately physically touched CNA 2 during personal care. He tried to kiss the employee. He was redirected and the employee asked him to stop and the behavior gradually improved. The handwritten note was provided after the start of the survey and was not located in Resident C's medical record. A handwritten document, titled Behavior Sheet, dated 6/22/25, indicated Resident C was touching the inner thighs of CNA 3 inappropriately while she was checking and changing him. She provided instructions to him or redirected him, and his behavior improved gradually.The handwritten note was provided after the start of the survey and was not located in Resident C's medical record. A nursing progress note, dated 6/22/25 at 3:26 p.m., indicated Resident C was forgetful and confused. At times, he had to be redirected because he went into other residents' rooms and needed friendly reminders of where his room was located. A nursing progress note, dated 6/23/25 at 10:14 a.m., indicated Resident C needed reminders not to touch other residents.A nursing progress note, dated 6/23/25 at 3:19 p.m., indicated Resident C's physician saw the resident and wrote a new order for medroxyprogesterone (a synthetic progestin used in men primarily for treating abnormal sexual behaviors by reducing testosterone levels) 5 mg (milligram) by mouth every day. An initial psychiatry consultation note, dated 6/23/25, indicated the reason for the visit was to assess Resident C's mental illness and manage his medication. He had a history of depression and dementia and presented for an evaluation for increased sexual behaviors. He had been exhibiting increased sexual behaviors, including inappropriate touching of female staff and reports of masturbation in his room. He was not a danger to himself or others. He was having sexual aggression. His Brief Interview for Mental Status (BIMS) assessment, on 5/26/25, score was 10, which indicated a moderately cognitive impairment. He had a diagnosis of dementia with behavioral disturbance. Staff had reported he had increased sexual behaviors and masturbation which were new developments for this resident. Progesterone therapy at 5 mg daily was initiated to manage his sexual behavioral disturbances. A physician's order, dated 6/24/25, indicated to give medroxyprogesterone acetate 5 mg by mouth once a day for inappropriate sexual behaviors. The Electronic Medication Administration Record (EMAR), for June 2025, indicated Resident C received medroxyprogesterone acetate 5 mg on 6/24/25 through 6/30/25. The EMAR lacked documentation the resident was being monitored for inappropriate sexual behaviors.The EMAR, for July 2025, indicated Resident C received medroxyprogesterone acetate 5 mg on 7/1/25 through 7/10/25. The EMAR lacked documentation the resident was being monitored for inappropriate sexual behaviors. Resident C had a care plan which addressed the problem he had socially inappropriate behavior at times such as invading other female resident and staffs' personal space. The interventions included educating Resident C on what was and was not appropriate (the resident had a diagnosis of dementia), psychiatric evaluation as needed and validating his feelings. The care plan and interventions were not initiated until 7/9/25.There was no documentation located in Resident C's record which indicated the facility was monitoring the resident's inappropriate sexual behaviors. The resident's record lacked a behavioral care plan with specific interventions to address inappropriate sexual behaviors prior to the initiation of a medication to control his behavior. The resident's record lacked documentation the risks and benefits of the medication to control Resident C's behaviors were discussed the resident's representative. During an interview, on 7/17/25 at 3:30 p.m., the Executive Director indicated that a resident's inappropriate sexual behaviors would be documented in the electronic medical record in the progress notes. During an interview, on 7/18/25 at 3:32 p.m., LPN 6 indicated she had not seen Resident C have any inappropriate sexual behaviors with staff members or female residents. During an interview, on 7/18/25 at 3:42 p.m., CNA 7 indicated once Resident C had

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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 ensure a resident's behaviors were documented in the electronic medical record for 1 of 3 residents reviewed for a complete and accurate clinical record. (Resident C)Findings include:The clinical record for Resident C was reviewed on 7/17/25 at 10:06 am. The diagnoses included, but were not limited to, dementia, cognitive communication deficit, and muscle weakness. The following were provided by the Executive Director, on 7/18/25 at 11:00 a.m.:A handwritten document, titled Behavior Sheet, dated 6/17/25, indicated Resident C had a sexually inappropriate behavior when he grabbed CNA 1's butt with both his hands. She was standing him up to move him to his wheelchair when he touched her. The CNA provided the resident with instructions or redirected him, which improved the behavior immediately.The handwritten note was provided after the start of the survey and was not located in Resident C's medical record. A handwritten document, titled Behavior Sheet, dated 6/21/25, indicated Resident C inappropriately physically touched CNA 2 during personal care. He tried to kiss the employee. He was redirected and the employee asked him to stop and the behavior gradually improved. The handwritten note was provided after the start of the survey and was not located in Resident C's medical record. A handwritten document, titled Behavior Sheet, dated 6/22/25, indicated Resident C was touching the inner thighs of CNA 3 inappropriately while she was checking and changing him. She provided instructions to him or redirected him, and his behavior improved gradually.The handwritten note was provided after the start of the survey and was not located in Resident C's medical record. A handwritten document, titled Behavior Sheet, dated 6/25/25, indicated Resident C was touching CNA 4 inappropriately. She provided instructions and/or redirection and used conflict resolution, and his behavior did not improve. The handwritten note was provided after the start of the survey and was not located in Resident C's medical record. During an interview, on 7/17/25 at 3:30 p.m., the Executive Director indicated that a resident's inappropriate sexual behaviors would be documented in the electronic medical record in the progress notes. A current facility policy, titled Guidelines for Handling and Addressing Behavioral Emergencies, dated 3/18/23 and provided by the Regional Nurse Consultant on 7/18/25 at 12:20 p.m., indicated .Documentation in the clinical record should include facts as related to time, possible causative factors, actual behavior with the consequences, interventions and outcomes