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	05/15/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents were administered the correct medications for 2 of 4 residents reviewed for significant medication errors. (Resident B and C) The deficient practice was corrected on 5/11/26, prior to the start of the survey, and was therefore past noncompliance.Findings include:During an interview, on 5/14/26 at 8:11 a.m., the Director of Nursing (DON) indicated two medication errors occurred recently. Resident B had been administered Resident D's medications and Resident C had been administered Resident E's medications. Resident B was observed overnight in the emergency room, and Resident C was monitored at the facility. 1. The clinical record for Resident B was reviewed on 5/14/26 at 10:15 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, a history of falling, anxiety disorder, dementia, unsteadiness on feet, and pulmonary fibrosis. A facility document, titled Medication Error, dated 5/8/26 at 7:04 p.m., indicated Resident B had been administered medications which were not prescribed to her. She was sent to the hospital for evaluation. She was kept overnight for observation and sent back to the facility in the morning on 5/9/26. The medications she received which were not ordered for her were:a. Lyrica (a controlled substance medication used to treat seizures or nerve pain) 50 milligrams (mg).b. Zyprexa (an atypical antipsychotic used to treat mental health conditions such as; schizophrenia and bipolar disorder) 2.5 mg.c. Trazadone (an antidepressant medication also used to treat insomnia) 50 mg.d. Metoprolol (a medication used to treat high blood pressure which slows the heart rate and decreases the force of the heart's contractions) 12.5 mg.e. Eliquis (an anticoagulant medication which thins the blood) 2.5 mg.The Electronic Medication Administration Record (EMAR) for Resident B, dated May 2026, did not indicate Lyrica, Zyprexa, trazadone, metoprolol or Eliquis were her prescribed medications. The clinical record indicated, from 2/13/26 to 5/15/26, Resident B's pulse (measure of heart rate) typically ran from 55 bpm (beats per minute) to 88 bpm. Resident B's pulse had dropped down to 55 and 58 two (2) times then the rest of the time her pulse ranged 60 to 88 bpm.A hospital document, titled ED Physician Progress Note, dated 5/9/26 at 7:06 a.m., indicated Resident B was transported to the emergency room for evaluation and treatment after a medication error. She was accidentally administered medication which was meant for another resident. Resident B was administered Eliquis 2.5 mg, Lyrica 50 mg, metoprolol 12.5 mg, trazadone 50 mg, and Zyprexa 2.5 mg. At her baseline, she was only routinely oriented to person. The physician observed bradycardia on the physical exam as well as the resident was drowsy but awoke to stimuli. The physician called the Indiana Poison center, who indicated there was no specific therapy and they would not expect her to have any substantial complications. Their recommendation was to observe her. The resident was observed in the emergency room until 7:00 a.m., on 5/9/26, on a heart monitor. She slept all night. She was bradycardic in the upper 40's to 50's. She had some hypotension in the middle of the night. Her vital signs ranged from 46 to 53 bpm and her blood pressure dropped to as low as 80/46 while being monitored. The resident woke up to verbal stimuli but quickly fell back to sleep. The discharge diagnosis was medication administered in error. Patient education included accidental overdose of an adult. During a telephone interview, on 5/15/26 at 4:36 p.m., LPN 2 indicated she was passing medications when a resident began yelling and screaming. She put Resident D's medications in the cart after marking the cup with her first and last initial. After she took care of the resident, she (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

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	05/15/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	went back to her cart and picked up the medication cup. She took the medications and administered them to Resident B instead of Resident D. The Nurse Practitioner was notified of the error and ordered an evaluation at the emergency room because she was concerned about the Zyprexa medication Resident B received.2. The clinical record for Resident C was reviewed on 5/14/26 at 12:20 p.m. The diagnoses included, but were not limited to, dementia, chronic kidney disease, major depressive disorder, unsteadiness on feet, muscle weakness, and metabolic encephalopathy. A telehealth note, dated 4/27/26 at 1:00 a.m., indicated Resident C had been administered medications in error by a nurse. The diagnosis was accidental medication error. The clinician ordered Resident C's vital signs to be checked every two hours for 24 hours and to notify the clinician of any change in condition. The medications included:a. atorvastatin (a medication used to decrease cholesterol levels).b. Plavix (an antiplatelet medication)c. Metoprolol (a medication used to treat high blood pressure which slows the heart rate and decreases the force of the heart's contractions) The Electronic Medication Administration Record (EMAR) indicated Resident C was administered Plavix 75 mg, buspirone (a medication used to treat anxiety) 15 mg, metformin (a medication used to lower blood sugar levels in someone with diabetes mellitus) 500 mg (2 tablets), metoprolol, and duloxetine (an antidepressant medication) 40 mg. Resident C was administered 1000 mg of metformin without a physician's order and without a diagnosis of diabetes mellitus. There was no documentation in Resident C's clinical record to indicate her blood sugars were monitored after receiving an incorrect medication of metformin. During a telephone interview, on 5/15/26 at 5:37 p.m., QMA 3 indicated she administered Resident E's medication to Resident C. She was a new Qualified Medication Aide (QMA). It was her first time out of orientation and the first time she had passed medications in that hallway. The internet went down when she was passing medications and she did not know what to do. So, she passed the medications based off the resident's roll of medications in the drawer. She had the residents mixed up and administered Resident C, Resident E's medication.A current facility policy, titled Six Rights of Medication Administration, dated September 2013 and provided by the Executive Director on 5/15/26 at 11:45 a.m., indicated .before administering the medication.Right RESIDENT-identify resident to assure you are giving the medication to the resident who is supposed to receive the medication and using procedure required by the facility, such as photo on the MAR [Medication Administration Record], asking a resident his/her name, etc. Right MEDICATION-the name of the medication ordered by the physician The deficient practice was corrected by 5/11/26 after the facility implemented a systemic plan that included the following actions: All nursing staff were educated on the administration of medications, the LPN and QMA involved had the medication administration policy reviewed with them and completed a medication administration pass competency. Audits and medication pass competency had begun and continued. This citation relates to Intake 3011150.410 IAC (Indiana Administrative Code) 16.2-3.1-48(c)(2)