STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Georgetown, The	1002 Sister Barbara Way Georgetown, IN 47122

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 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. 34231 Based on interview and record review, the facility failed to ensure an allegation of abuse was thoroughly investigated for 1 of 3 residents reviewed for abuse. (Resident P) Findings include: The incident report, dated 3/24/25 at 10:30 a.m., indicated Resident P reported that she felt RN (Registered Nurse) 6 was sexually inappropriate during care. The clinical record for Resident P was reviewed on 3/26/25 at 2:57 p.m. The resident's diagnoses included, but were not limited to, diabetes, anxiety, insomnia and GERD (gastroesophageal reflux disease). The quarterly Minimum Data Set (MDS) assessment, dated 1/31/25, indicated the resident's cognition was intact. During an interview, on 3/24/25 at 3:11 p.m., Resident P indicated RN 6 had come to her room to give her evening medications. RN 6 asked Resident P if she needed something to help her sleep and Resident P told her if she had one prescribed. RN 6 responded I did not ask you that. RN 6 told Resident P that she loved her, she was beautiful and that she did not think Resident P was crazy. RN 6 rubbed Resident P's left arm and leg and then nuzzled (rub or push against gently with the nose and mouth) her neck. She told RN 6 that what she did made her uncomfortable and then RN 6 left. She reported what had happened to Certified Nurse Aide (CNA) 7, who then reported the incident to Licensed Practical Nurse (LPN) 8. LPN 8 came over and she told her what had happened. During an interview, on 3/26/25 at 1:14 p.m., CNA 7 indicated RN 6 seemed a little touchy/feely when she worked with her. Resident P reported to her that RN 6 rubbed her arms and kissed her on the neck. RN 6 asked Resident P if she wanted a sleeping pill and Resident P responded if I have one prescribed. RN 6 then said I did not ask you that. CNA 7 reported the incident to LPN 8. (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: 155770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/26/25 at 11:18 a.m., LPN 8 indicated CNA 7 reported that RN 6 made Resident P feel uncomfortable by rubbing her hand and telling the resident she loved her. LPN 8 tried to get more information but Resident P was confused. Resident P did not want RN 6 to be her nurse. RN 6 denied the incident and was not suspended per the Director of Nursing (DON). Normally, the facility would suspend the staff member during an investigation. There was a couple of times staff had called and reported an odor of alcohol on RN 6. One time, she assessed the RN and RN 6 had no smell of alcohol. LPN 8 moved LPN 9 to Villa 6 for the rest of the shift. LPN 8 did not interview any other staff or residents in Villa 6 or Villa 7. On 3/27/25 at 9:18 a.m., the Regional Nurse Consultant provided a current copy of the document titled Abuse Prevention Program dated 10/22/22. It included, but was not limited to, It is the policy of this facility to prevent abuse, neglect .Each resident receives care and services in a person-centered environment in which all individuals are treated a human beings .Employees are required to report any incident, allegation or suspicion of potential abuse .to the Administrator or immediate supervisor who will immediately report the allegation to the Administrator .Upon learning of the report, the Administrator or in the absence of the Administrator, the person in charge of the facility shall initiate an incident investigation .All incidents will be documented, whether of not abuse occurred, was alleged or suspected .Any .allegation involving abuse .will result in an abuse investigation .The Charge Nurse must complete an incident report and obtain a written, signed and dated statement from the person reporting the incident .Staff members who are suspected of abuse or misconduct shall immediately . be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation This Citation relates to Complaint IN00456149 3.1-28(c) 3.1-28(d)

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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 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

34231

Based on interview and record review, the facility failed to ensure residents (Resident D, Resident F and Resident G) were monitored for medication side effects and failed to ensure treatments were completed for a resident (Resident L) for 4 of 4 residents reviewed for quality of care.

Findings include:

1. The clinical record for Resident D was reviewed on 3/24/25 at 4:48 p.m. The diagnoses included, but were not limited to, diabetes, peripheral vascular disease and systemic lupus.

The physician's order, dated 3/21/25, indicated to resident was to receive Eliquis (anticoagulant) 5 mg (milligrams) twice a day for DVT (deep vein thrombosis) prevention.

The care plan, dated 1/11/24, indicated the resident was at risk for bleeding due to anticoagulant medication use and to observe for signs and symptoms of complications which included blood tinged or frank blood in urine, black tarry stool, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, petechiae, diarrhea, muscle/joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden change in memory, changes in mental status, and significant sudden changes in vision.

The physician's order, dated 3/21/25, indicated the resident was to receive Insulin Lispro (short acting insulin) per sliding scale before meals and at bedtime.

The care plan, dated 2/10/22, indicated the resident had diabetes and to monitor for signs and symptoms of hypoglycemia and hyperglycemia.

The clinical record lacked documentation of monitoring for side effects related to diabetes and anticoagulant use upon readmission on 3/21/25.

During the survey period, between 3/24/25 and 3/27/25, Staff Member 10 indicated if a resident was on a blood thinner, nursing staff should monitor every shift for signs and symptoms of bleeding anywhere, bruising, blood clots and black tarry stools and documenting the assessment on the medication administration record (MAR or treatment administration record (TAR). Diabetics should be monitored ever shift for signs and symptoms of hypoglycemia and hyperglycemia and documented on the MAR/TAR. Residents who receive diuretics should be monitored for signs of dehydration and the assessment should be documented on the MAR/TAR.

2. The clinical record for Resident F was reviewed on 3/24/25 at 2:08 p.m. The resident's diagnoses included, but were not limited to, right sided hemiplegia and hemiparesis secondary to cerebral vascular accident, diabetes, hyperlipidemia and hypertensive heart disease.

The physician's order, dated 3/7/25, indicated the resident was to receive Warfarin (blood thinner) 5 mg every evening for cerebral vascular accident.

(continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, dated 3/7/25, indicated the resident had the potential for complications related to anticoagulant use and to observe for reactions such as nausea, hemorrhage, fever, rash, bruise easily, angioedema, anaphylaxis and thrombocytopenia. The clinical record lacked documentation for the monitoring of the possible reactions and/or complications. 3. The clinical record for Resident G was reviewed on 3/26/25 at 8:55 a.m. The resident's diagnoses included, but were not limited to hypertension and congestive heart failure. The physician's order, dated 3/12/25, indicated the resident was to receive Lasix (diuretic) 80 mg daily for congestive heart failure. The physician's order, dated 3/21/25, indicated the resident was to receive Lasix 20 mg in the afternoon for edema. The care plan, dated 3/25/25, indicated the resident was at risk for fluid volume deficit due to diuretic use and to observe for signs and symptoms of dehydration. The clinical record lacked documentation for the monitoring of signs and symptoms of dehydration related to the diuretic use. 4. The clinical record for Resident L was reviewed on 3/27/25 at 10:54 a.m. The resident's diagnosis included, but was not limited to, abdominal wall abscess. The physician's order, dated 2/16/25, indicated to pack the surgical wound next to the stoma with gauze four times a day at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. for a wound infection. The March 2025 treatment administration record indicated the treatment was not completed on the following dates and times: - On 3/01/25 at 12:00 a.m. and 6:00 a.m. - On 3/03/25 at 6:00 p.m. - On 3/04/25 at 6:00 p.m. - On 3/08/25 through 3/12/25 at 6:00 a.m. - On 3/15/25 through 3/16/25 at 6:00 a.m. - On 3/22/25 at 6:00 a.m. This Citation relates to Complaint IN00456149 3.1-37

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Waters of Georgetown, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 Sister Barbara Way Georgetown, IN 47122	

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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 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. 34231 Based on interview and record review, the facility failed to ensure Indwelling catheter care was provided for a resident and failed to ensure urine output was documented as ordered for 2 of 2 residents reviewed for Indwelling catheters. (Resident K and Resident L) Findings include: 1. The clinical record for Resident K was reviewed on 3/27/25 at 10:20 a.m. The resident's diagnosis included, but was not limited to, urinary retention. The care plan, dated 1/3/25, indicated the resident had an Indwelling catheter and staff were to provide catheter care every shift and document the resident's urine output every shift. The physician's order, dated 1/3/25, indicated to provided catheter care every shift. The physician's order, dated 2/26/25, indicated to record catheter output every shift for monitoring. The March 2025 medication administration (MAR) lacked documented urine output on the following dates and shifts: - On 3/3/25 and 3/4/25, there were no documented urine output on day shifts. - On 3/7/25 and 3/8/25, there were no documented urine output on night shifts. - On 3/10/25, there was no documented urine output on night shift. - On 3/13/25, there was no documented urine output on day shift. - On 3/17/25, there was no documented urine output on night shift. - On 3/18/25 and 3/19/25, there were no documented urine output on day shifts. - On 3/21/25, there was no documented urine output or catheter care on night shift. During an interview, from 3/24/25 through 3/27/25, Staff Member 10 indicated all physicians' orders should be followed as well as a resident's plan of care. On 3/27/25 at 9:18 a.m., the Regional Nurse Consultant provided a current copy of the document titled Physician Orders/Following Physician Orders Guideline dated 2/15/19. It included, but was not limited to, It is the policy of this facility to follow the orders of the physician .The facility will follow physician orders to provide essential care to the resident (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The clinical record for Resident L was reviewed on 3/27/25 at 10:54 a.m. The resident's diagnosis included, but was not limited to, neuromuscular dysfunction of the bladder. The care plan, dated 2/20/25, indicated the resident had an Indwelling catheter and staff were to document the resident's urine output every shift. Review of the resident's March 2025 treatment administration record (TAR) lacked documentation of the resident's urine output on the following dates and shifts: - On 3/4/25, there was no urine output documented on day shift. - On 3/7/25 and 3/8/25, there were no urine output documented on night shifts. - On 3/10/25 through 3/12/25, there were no urine output documented on night shifts. - On 3/13/25, there was no urine output documented on day shift. This Citation relates to Complaint IN00456149 3.1-41(a)(2)

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 34231 Based on interview and record review, the facility failed to ensure a resident's (Resident L) ostomy output was documented and care of the ostomy completed, as ordered by the physician for 1 of 1 resident reviewed for ostomy care. Findings include: The clinical record for Resident L was reviewed on 3/27/25 at 10:54 a.m. The resident's diagnosis included, but was not limited to, ostomy status. The care plan, dated 2/20/25, indicated the resident had an ostomy surgical site and staff were to administer the resident's treatments as ordered. The physician's order, dated 2/15/25, indicated to provide ostomy care and record any liquid output every shift. The resident's March 2025 treatment administration record lacked documentation of care provided and the resident's output on the following dates and shifts: - On 3/4/25, there was no output documented on day shift. - On 3/7/25 and 3/8/25, there were no output documented on night shifts. - On 3/10/25 through 3/12/25, there were no output documented on night shifts. - On 3/13/25, there was no output documented on day shift. - On 3/21/25, there was no ostomy care completed. This Citation relates to Complaint IN00456149 3.1-47(a)(3)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34231 Based on observation, interview and record review, the facility failed to ensure the facility was adequately staffed to provide adequate care and safety for the residents. This deficient practice had the potential to affect 67 of 67 residents residing in the facility. Findings include: During an interview, between 3/24/25 and 3/27/25, Staff Member 11 indicated there was supposed to be an aide in every Villa but that did not always happen. When Staff Member 11 had two [NAME] to administer medications, Staff Member 11 would have to flip flop with the aide in Villa 3 which would leave the residents in Villa 1 alone with no staff in the building for approximately two minutes. There had, however been times when Villa 1 had been left unattended for 5 to 10 minutes. The way the facility staffed the [NAME] was not safe nor was it fair to the residents. During an interview, between 3/24/25 and 3/27/25, Certified Nurse Aide (CNA) 12 indicated the facility was currently short staffed. She had cared for residents that required assistance of two staff members and frequently had to wait to change residents or put them to bed until another staff member could assist her. For the most part, CNA 12 could complete all tasks assigned, however, when she worked in Villa 5, she was not able to complete her showers. During an interview, between 3/24/25 and 3/27/25, Qualified Medication Aide (QMA) 13 indicated she had worked as the nurse and the aide in a Villa many times. When you have to administer medication, provide resident care and serve all the meals during the 12-hour shift, it was like running around like a chicken with its head cut off and impossible to complete all care tasks, especially showers. During an interview, between 3/24/25 and 3/27/25, Licensed Practical Nurse (LPN) 5 indicated it was hard to complete all of her assigned tasks. LPN 5 sometimes times had to leave her Villa for long periods of time to administer insulin in multiple [NAME] where there were QMA's working. During an interview, between 3/24/25 and 3/27/25, LPN 10 indicated she has had to work two [NAME] before due to no nurses available. There had been a lot of QMA's working so the nurses had to leave their [NAME] to administer insulin in the other [NAME]. There had been times when LPN 10 would have to go to another Villa to assess a resident and, at times, send the residents out to the hospital. When that happened, your aide was left alone in the Villa for longer periods of time. The current staffing was not safe and was definitely not fair to the residents. During an interview, between 3/24/25 and 3/27/25, CNA 14 indicated she has had to work Villa 7 by herself multiple times which was very difficult. All the residents in the Villa received therapy and they also had heightened needs. There were times when she would be toileting one resident, and she could hear two other residents yelling because they needed to go to the bathroom at the same time. It makes it very hard when you are in a Villa by yourself. Review of the February 2025 and March 2025 as worked staffing sheets indicated the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 2/11/25, there was no nurse in Villa 3 on night shift. - On 2/24/25, there was no nurse in Villa 3 on night shift. - On 3/15/25, there was no aide in Villa 4 on night shift. - On 3/24/25, there was one nurse for Villa 5 and Villa 6 on day shift. - On 3/25/25, there was no nurse in Villa 3 on night shift. - On 3/27/25, there was one nurse for Villa 5 and Villa 6 on day shift. During an observation, on 3/25/25 at 11:22 a.m., Villa 5 was observed without a nurse. CNA 15 indicated RN (Registered Nurse) 16 was currently over in Villa 6 giving medications. The incident report, dated 3/25/25 at 5:30 p.m., indicated a resident from Villa 5 exited the facility, in his wheelchair without supervision. The resident was re-directed back to the Villa by the Director of Rehabilitation. During an interview, on 3/27/25 at 1:55 p.m., CNA 15 indicated right after dinner, RN 16 had to go over to Villa 6 to send a resident out to the hospital since she was covering Villa 5 and Villa 6. CNA 15 was in a room, with the door closed, providing care for a resident. Her pager started going off while she was in the room, so she hurried up and completed care on the resident. When she came out of the room, she heard the door alarm sounding. She could not hear the door alarm because she was in a resident's room with the door closed. When she looked out the door, she saw therapy bringing the resident whom had exited back into Villa 5. 3.1-17(a)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34231 Based on interview and record review, the facility failed to ensure a resident's (Resident H) scheduled narcotic was administered, as ordered by the physician, for 1 of 3 residents reviewed for medications errors. Findings include: The clinical record for Resident H was reviewed on 3/27/25 at 9:59 a.m. The resident's diagnoses included, but were not limited to, depression, anxiety and age-related osteoporosis. The care plan, dated 3/7/25, indicated the resident was at risk for pain and to administer medications as ordered. The care plan, dated 3/7/25, indicated the resident had an anxiety disorder and to give anti-anxiety medication as ordered by the physician. The physician's order, dated 3/19/25, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 10-325 mg (milligrams) every 6 hours at 6:00 a.m., 12:00 p.m., 6:00 p.m. and 12:00 a.m. for pain. The physician's order, dated 3/6/25, indicated the resident was to receive Xanax (narcotic anti-anxiety medication), 1 mg every 6 hours at 6:00 a.m., 12:00 p.m., 6:00 p.m. and 12:00 a.m. for anxiety. Review of the March 2025 medication administration record indicated the resident did not receive the pain medication or the anti-anxiety medication on 3/22/25 at 6:00 a.m. Review of the controlled drug record for March 2025 indicated the that neither the Hydrocodone or Xanax were signed out as administered. During an interview, from 3/24/25 through 3/27/25, Staff Member 10 indicated all physicians' orders should be followed. On 3/27/25 at 9:18 a.m., the Regional Nurse Consultant provided a current copy of the document titled Physician Orders/Following Physician Orders Guideline dated 2/15/19. It included, but was not limited to, Policy .It is the policy of the facility to follow the orders of the physician This Citation relates to Complaint IN00456149 3.1-48(c)(1)

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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 - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34231 Based on interview and record review, the facility failed to ensure unavailable medications were not documented as administered for 1 of 6 residents (Resident E); failed to ensure resident medication administration records accurately reflected the administration of medications for 5 of 6 residents (Resident D, Resident G, Resident H and Resident M); and failed to ensure a resident's (Resident E and Resident L) medication administration record accurately reflected the administration of narcotic pain medication for 2 of 3 reviewed for documentation. Findings include: 1. The clinical record for Resident D was reviewed on 3/24/25 at 4:48 p.m. The resident's diagnosis included, but was not limited to, hypothyroidism. The physician's order, dated 4/18/24, indicated the resident was to receive Levothyroxine Sodium Tablet, 100 mcg (micrograms) daily at 6:00 a.m. The March 2025 medication administration record (MAR) lacked documentation of the administration of the medication on 3/6/25, 3/9/25, 3/12/25 and 3/16/25. During an interview, on 3/25/25 at 1:28 p.m., RN (Registered Nurse) 6 indicated the medication administration record should be signed to show a medication was administered. On 3/27/25 at 9:18 a.m., the Regional Nurse Consultant provided a current copy of the document titled Medication Administration Guideline dated 1/25/19. It included, but was not limited to, Policy .Medications are administered as prescribed .The resident's MAR is initialed by the person administering a medication . When PRN medications are administered, the following documentation is provided .Date and time of administration .Signature or initial of person recording administration 2. The clinical record for Resident E was reviewed on 3/24/25 at 1:38 a.m. The resident's diagnoses included, but were not limited to, constipation and cellulitis of the right lower extremity. The resident admitted to the facility on [DATE] at 5:50 p.m. The March 2025 MAR record indicated the resident received the following medications: - 3/21/25 at 8:00 p.m., Colace (medication for constipation) 100 mg (milligrams) - 3/21/25 at 8:00 p.m., Linezolid (antibiotic) 600 mg - 3/21/25 at 8:00 p.m., Lovenox Injection (blood thinner) 0.4 ml (milliliters) subcutaneously - 3/22/25 at 12:00 a.m., Amoxicillin (antibiotic) 500 mg Review of the pharmacy delivery sheet indicated medications for the resident did not arrive to the facility until 3/22/25 at 7:14 a.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 3/25/25 at 9:20 a.m., the Regional Nurse Consultant indicated there were no medications pulled from the EDK (emergency drug kit) on 3/21/25 for administration. During an interview, on 3/25/25 at 1:28 p.m., RN 6 indicated she worked night shift on 3/21/25. She could not recall if she signed off medications as administered for Resident E. If a medication was not available for administration, the medication should not be signed out as given. The physician's order, dated 3/21/25, indicated the resident was to receive Oxycodone HCl (narcotic pain medication) 10 mg every four hours as needed for pain. The March 2025 controlled drug record indicated the resident received the medication on 3/23/25 at 4:00 a. m. and 3/24/25 at 4:00 a.m. The March 2025 MAR lacked documentation of the administration of the narcotic pain medication. During an interview, on 3/27/25 at 1:55 p.m., Licensed Practical Nurse (LPN) 5 indicated if an as needed narcotic pain was administered, it should be signed off on the controlled drug record and the medication administration record to show the medication was administered. 3. The clinical record for Resident G was reviewed on 3/26/25 at 8:55 a.m. The resident's diagnoses included, but were not limited to, hypothyroidism, chronic obstructive pulmonary disease, gastrostomy status, anxiety and atrial fibrillation. The physician's order, dated 3/12/25, indicated the resident was to receive Levothyroxine Sodium tablet 125 mcg daily at 6:00 a.m. The March 2025 MAR lacked documentation of the administration of the medication on 3/15/25 at 6:00 a.m. and 3/22/25 at 6:00 a.m. The physician's order, dated 3/19/25, indicated the resident was to receive Insulin Lispro (fast acting insulin) per sliding scale every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. The March 2025 MAR lacked documentation of a blood sugar check or insulin administration on 3/22/25 at 6:00 a.m. and 3/23/25 at 6:00 a.m. The physician's order, dated 3/12/25, indicated the resident was to receive guaifenesin liquid 10 ml (milliliters) every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. The March 2025 MAR lacked documentation of the administration of the medication 3/15/25 at 6:00 a.m. and 3/22/25 at 6:00 a.m. The physician's order, dated 3/13/25, indicated the resident was to receive Meropenem (antibiotic) intravenously every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. for 14 doses related to cellulitis. The March 2025 MAR lacked documentation of the administration of the medication on 3/15/25 at 6:00 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER: Waters of Georgetown, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 1002 Sister Barbara Way Georgetown, IN 47122	

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The clinical record for Resident H was reviewed on 3/27/25 at 9:59 a.m. The resident's diagnosis included, but was not limited to, hypothyroidism. The physician's order, dated 3/5/25, indicated the resident was to receive Levothyroxine Sodium 137 mcg daily at 6:00 a.m. The March 2025 MAR lacked documentation of the administration of the medication on 3/12/25 at 6:00 a.m. and 3/22/25 at 6:00 a.m. 5. The clinical record for Resident L was reviewed on 3/27/25 10:54 a.m. The resident's diagnoses included, but were not limited to, diabetes and cutaneous abscess of the abdominal wall. The physician's order, dated 2/14/25, indicated the resident was to receive Hydrocodone/APAP 7.5/325 mg every six hours as needed. The March 2025 controlled drug record indicated the resident received the narcotic pain medication on the following dates and times: - 3/01/25 at 5:30 p.m. - 3/03/25 at 3:30 a.m. - 3/05/25 at 10:00 p.m. - 3/09/25 at 10:00 p.m. - 3/10/25 at 5:30 p.m. - 3/11/25 at 5:30 p.m. - 3/15/25 at 2:00 p.m. - 3/17/25 at 12:00 a.m. The resident's March 2025 MAR lacked documentation of the administration of the narcotic medication. 6. The clinical record for Resident M was reviewed on 3/27/25 at 11:17 a.m. The resident's diagnosis included, but was not limited to, hypothyroidism. The physician's order, dated 2/7/25, indicated the resident was to receive Levothyroxine Sodium 50 mcg daily at 6:00 a.m. The March 2025 MAR lacked documentation of the administration of the medication on 3/12/25 at 6:00 a.m. and 3/22/25 at 6:00 a.m. This Citation relates to Complaint IN00456149 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Waters of Georgetown, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 Sister Barbara Way Georgetown, IN 47122	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-50(a)(2)