

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  06/16/2025
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to ensure adequate supervision for a resident at risk for elopement for 1 of 5 residents reviewed for accidents hazards. (Resident B).</p> <p>Findings include:</p> <p>The record for Resident B was reviewed on 6/10/25 at 9:48 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and dementia.</p> <p>The care plan, dated 8/16/24 and revised on 5/23/25, indicated the resident was an elopement risk or wanderer, disoriented to place, impaired safety awareness, and a history of leaving a previous facility unsupervised. The interventions included, but were not limited to: assist in reorientation to the room and facility using verbal cues and reminders; the courtyard gate was to be locked with padlock; distract the resident from wandering by offering pleasant diversions, (conversation or offer snack) structured activities, food, conversation, television, and/or book; notify social services and/or the administrator for persistent attempts to leave the building and not respond to redirection; observe for and document wandering and/or exit seeking behavior and attempted diversionary interventions as needed; observe the resident's location with visual checks during rounds and as needed; and put familiar items in the resident's room to assist in identifying room.</p> <p>The incident note, dated 5/22/25 at 5:45 p.m., indicated at approximately 5:45 p.m., the doorbell rang. The nurse answered the door and Resident B was at the door waiting to come in. When asked how Resident B got out there, she indicated, I can't tell you or you'll know my secret. A head-to-toe assessment was completed. The doors were checked and working properly. The patio gate lock was observed to be unlatched.</p> <p>The nurses note, dated 5/24/25 at 6:59 p.m., indicated the resident had been sitting outside on the patio. The resident walked up to the patio gate and started pushing on it. The resident asked the staff to open the doors so she could go outside for a walk. Once she asked to go outside to look for her car. The resident asked the staff if we could sneak outside.</p> <p>The nurse's note, dated 5/29/25 at 5:31 p.m., indicated</p> <p>the resident went out with a family member. The resident returned for lunch and family members and the resident went out for 30 to 60 minutes or longer. The resident had attempted to follow two sets of visitors out the front door when they left.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 6/11/25 at 11:20 a.m., LPN 4 indicated she was the nurse on duty when the resident went out the gate. She was responsible for [NAME] 6 and 8. At the time the resident left the courtyard she was in Villa 6. There was 1 Certified Nursing Aide (CNA) in the building, and she was assisting another resident. When she left Villa 6, she entered the back entrance of Villa 8. As she entered the unit the CNA was coming out of a resident room. She heard the doorbell ring and when she answered the door the resident was standing there. The resident would not tell staff how she left the building. The resident had a scared look on her face. The resident couldn't have been gone any longer than 15 minutes. The staff inspected all the doors and alarms. When she inspected the courtyard gate it was unlocked and opened. The gate had a padlock on it and only the maintenance man and the nurse had a key. She never used the gate to go out. The resident would sit and watch the doors and had tried to leave with visitors before. Management had discontinued all wander guards, and she felt like the wander guards would help alert staff.</p> <p>During an interview, on 6/12/25 at 10:11 a.m., the Executive Director (ED) indicated they could not determine how the gate was unlocked. She indicated she did not know what happened.</p> <p>During an interview, on 6/12/25 at 1:00 p.m., CNA 8 indicated she was assisting another resident to bed, and it took a while to get her in bed. After she assisted the resident to bed, she left the room and saw the nurse entering through the back door. She had been in another villa with those residents. They heard the doorbell ring, and the nurse went to answer the door, and it was Resident B. They were unsure how the resident got out of the facility. Management was notified and all the exit doors were checked. They took a count of the residents and checked the alarms. Staff checked all areas of the [NAME] to make sure someone did come in and they weren't supposed to be there. She walked out to the courtyard and observed the gate unlocked. The gate had a padlock, but it was hanging on the latch unlocked. She did not know how the gate got unlocked.</p> <p>The Maintenance Director no longer worked at the facility, he left after the incident and was unavailable to interview.</p> <p>The Elopement and Missing Resident Prevention policy, dated 4/20/23, indicated .It is the policy of this facility that all residents are provided with adequate supervision to meet each resident's nursing and personal care needs. All residents will be assessed for behaviors or conditions that put them at risk for elopement .</p> <p>Cross Reference F725</p> <p>The facility failed to ensure sufficient nursing staff were always available to provide personal care and safety for residents.</p> <p>3.1-45(a)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. During a confidential interview, between 6/9/25 and 6/16/25, Staff 100 indicated there was only one CNA in each building. If a resident was a mechanical full body lift, sit to stand, or required two staff members for mobility/transfers or toileting, then they would have to call the nurse to come over and help, but sometimes there was a wait until they were free to come over. Some days were harder than others. Staff 100 indicated they had to make time to get all their work done, even on weekends. Showers were being given as they made sure they were. For the most part the villa cleaning got done, maybe not the full deep cleaning that was supposed to be done in 2 rooms every day.</p> <p>During a confidential interview between 6/9/25 and 6/16/25, Staff 101 indicated some [NAME] were harder out of all the [NAME] as there were residents who required a lot of care. There were several residents who required a full body mechanical lift to get up or to be put back to bed and that took two staff members to complete the task. The nurses were usually called from another villa to help the CNA do the mechanical full body lift or watched the villa while the CNA toileted residents or were giving showers. Sometimes there was a wait until the nurse finished what they were doing before coming over to help the CNA.</p> <p>During a confidential interview between 6/9/25 and 6/16/25, Staff 102 indicated there usually was a floater to several buildings to help that CNA with care of the heavier care residents. There was only one CNA for each building. Monday, Tuesday, and Wednesday were usually better than the four other days as that was when the number of floaters and staffing were good, not so on the other days. She indicated she worked several [NAME] and it was a struggle to get everything done by end of shift. The CNAs had too many tasks to do. They had to cook the meals sent over, serving them and cleaning up, cleaning the rooms, vacuuming and doing laundry, resident general care, toileting, ADL's (Activities of Daily Living) on those that needed help and showers. The CNAs were supposed to also do the activities. A lot of times a resident will suddenly tell the aide they needed to go to the bathroom in the middle of serving a meal. Staff would have to stop, take them to the bathroom, then come back and sanitized and re-gloved and had to re-heat the meal before finally serving the residents. The CNA had to make sure the nurse was in the villa before anyone was taken into the shower room or toileted. They were so afraid a resident would fall when the aide was in a room and might get hurt. When the shower or care was finished, they would come out and then the CNA tried to locate all the residents to be sure they were okay. She would not do a mechanical full body lift by herself for fear the resident would fall out of it and would get hurt. Some staff members just grabbed the mechanical full body lift and would go on even though two staff members were needed. Some days staff were just not able get to the daily cleaning of the rooms or the vacuuming as they were so busy. At times, staff had to put off a resident's shower because there was no time. Between one and two o'clock, they were able to get more done, but only if there were the supplies needed. If supplies or snacks/food from dietary were needed, they would have to call the another staff member to come over and cover the villa while the CNA went to get the items. If the staff member was not available, then they would have to call around to the other [NAME] or dietary to bring what was needed. She would love to have the time to do the ladies nails. The ladies loved it. Management did not come out and help.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a confidential interview, between on 6/9/25 and 6/16/25, Staff 103 indicated it was common for only one aide to be scheduled per villa. There were aides who floated between the [NAME] to help out. Having a floater really helped the CNA in doing care. Maybe there should be more CNAs to float. The aide really struggled to get the work done.</p> <p>During a confidential interview, between on 6/9/25 and 6/16/25, Staff 104 indicated there was only one CNA for each villa. There were times of not being able to get all the tasks done in caring for the residents although they tried really hard. If help was needed, they had to call the a staff member from the other [NAME] to come and help. They were usually alone with no floater. The staff were expected to do activities also. It got tough to get the residents all up, do their care, toilet or do showers, all the cleaning and vacuuming, cooking and laundry. With the assigned tasks, they were not able to do the activities that were scheduled. If a resident required two staff members for assistance or the use of a full body mechanical lift, they would have to call the nurse or other [NAME] to get someone to come over to help if available. Sometimes the residents had to wait on getting up or for care until the other person was free to come over and help.</p> <p>During a confidential interview, between 6/9/25 and 6/16/25, Staff 105 indicated they tried to do hair and nails for the ladies one time a week and would pitch in to help the single aide if able. They did not know who the floaters were but they never came to the villa. Some of the [NAME] really needed a second aide working depending on the acuity of the care the residents needed. It was tough for the day staff member as the night shift only got certain people up before they left. Then the day shift staff member had to get the rest of them up along with all their other duties. They remained a high risk for falls and skin issues with only one aide in each of the villa. It used to be two aides for the villa, but it changed about two years ago to one CNA.</p> <p>4. During a confidential interview, between 6/9/25 and 6/16/25, Staff 107 indicated one aide and one floating nurse were alone on the floor and that was common. If a staff member was called to help in another villa and they were providing care, no one would take care of a resident in need, even if it was necessary.</p> <p>During an interview, on 6/10/25 at 1:01 p.m., Resident C indicated they had been left alone in a villa with no other staff recently. They had not had any trouble yet. They would have to go get someone if they needed help.</p> <p>During a confidential interview, between 6/9/25 and 6/16/25, Staff 106 indicated no other staff was present in the villa, when one staff provided care. Staff 106 indicated there was a total of only two staff in the villa. It happened often. They had a lot of fall risks and one staff member had to wait to do a shower until the other returned. There was a lot of work to complete in a villa. Resident care was a big part of it. It could cause a lot of stress for new hires. The main issue was call-ins or a lack of scheduled staff. Staff were supposed to conduct activities and were asked to take residents to activities in other [NAME]. Staff would take turns staying in the villa if a resident wanted to go to an activity. They really needed 2 staff to stay in each villa. One resident was a fall risk because he would just get up on his own. When a staff member gave a shower and no one else was there, it made giving care to others difficult. They had sometimes skipped giving a thorough shower or adequate grooming if a staff member was alone in a villa. Showers had not been skipped in a long time, but it wasn't a great shower. It took 20 to 30 minutes for each resident when staff got the resident up in the morning. The toilet wouldn't get cleaned and the vacuuming didn't get completed at times.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During multiple observations, between 6/9/25 and 6/16/25, only one CNA and one nurse were in the villa. At times, no one was visible due to being in one resident's room. Three residents were sitting at the dining table in their wheelchairs or in a dining chair. No activity was being performed, and the residents were not usually communicating with each other. Other residents were observed lying in their beds asleep. Three female residents were observed sitting alone at the dining table and kitchen counter. The TV was on without sound in the hearth. A CNA was in a resident's room assisting a resident and no other staff were visible. Two residents required two staff for assistance with transfers. One of the two required a full body mechanical lift to be used and both were fall risks in a villa.</p> <p>During a confidential interview, between 6/9/25 and 6/16/25, Staff 108 indicated they had never worked in a villa where there were two CNAs and one nurse. The workload was difficult when there was only one CNA, because residents would have to wait on medications and communication with residents' families had to wait. Both staff had to perform physical transfers or when using a full body lift for transfers. One staff member had to monitor the villa when the other gave showers or was providing care.</p> <p>The review of the Villa Day Shift Duties, on 6/13/25 at 12:04 p.m., indicated the following was to be completed by a CNA each day:</p> <ul style="list-style-type: none"> <li>- Shower Schedule: Days Mondays and Thursdays for rooms [ROOM NUMBERS], Tuesdays and Fridays for rooms [ROOM NUMBERS], Wednesdays and Saturdays for rooms [ROOM NUMBERS], and Sundays for room [ROOM NUMBER].</li> <li>- Shower Schedule: Nights Mondays and Thursdays for room [ROOM NUMBER], Tuesdays and Fridays for room [ROOM NUMBER], Wednesdays and Saturdays for room [ROOM NUMBER], and Tuesdays for room [ROOM NUMBER].</li> <li>- If there was down time, please go to other [NAME] and grab any stock that was needed.</li> <li>- All toilets must be cleaned on every day, this was just days shift's responsibility.</li> <li>- Make sure all food was dated and labeled.</li> <li>- Deep cleans Mondays for rooms [ROOM NUMBERS], Tuesdays for rooms [ROOM NUMBERS], Wednesdays for rooms [ROOM NUMBERS], Thursdays for rooms [ROOM NUMBERS], and Fridays for rooms [ROOM NUMBERS].</li> <li>-Get Report from night shift aides, Receive pager and key, Record temperatures for all refrigerators/freezers/pantry.</li> <li>-Prepare breakfast. Obtain the temperature of food and record.</li> <li>-Start morning get ups. Check and change round on all residents.</li> <li>-7:45 a.m., serve room trays, serve the dining table from 8:00 a.m. to 8:30 a.m.</li> <li>-Collect all breakfast dishes and begin cleaning the kitchen. Obtain the dish sanitizer temperature, pass ice water to all elders at 10:00 a.m.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> <li>-Start POC charting.</li> <li>-First scheduled shower and complete skin man assessment.</li> <li>-Start the resident's laundry.</li> <li>-Do the remainder of the resident's get ups.</li> <li>-Check and change round on the residents.</li> <li>-Pick up and prepare lunch.</li> <li>-Set the dining room table.</li> <li>-Bring all residents out for lunch.</li> <li>-Lunch-Obtain food temperatures and record.</li> <li>-12:00 p.m., serve room trays, serve the dining table from 12:15 p.m. to 12:45 p.m.</li> <li>-Collect all lunch dishes and clean the kitchen.</li> <li>-Obtain the dish sanitizer temperature.</li> <li>-3:00 p.m. pass ice water to all residents.</li> <li>-Lay the residents down for afternoon naps.</li> <li>-Check and change rounds on the residents.</li> <li>-Conduct the second scheduled showers-Complete the skin man assessment.</li> <li>-Start resident's laundry.</li> <li>-Take lunch break.</li> <li>-Daily cleaning-Mondays and Thursdays mop the bathrooms, Wednesdays and Saturdays vacuuming. Tuesdays and Fridays delivery truck.</li> <li>-Begin getting residents up for dinner.</li> <li>-Check and change rounds on the residents.</li> <li>-Set the dining room table for dinner.</li> <li>-Dinner-obtain food temperatures and record.</li> <li>-5:00 p.m., serve room trays, 5:15 p.m. to 5:45 p.m., serve the dining table.</li> </ul> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> <li>-Wash the dinner dishes. Obtain the dish sanitizer temperatures.</li> <li>-Spot clean the remaining rooms.</li> <li>-Collect all trash from the resident's rooms and take it out.</li> <li>-Ensure all dirty cups and dishes are out of the rooms.</li> <li>-Turn in the sheet to the nurse to ensure all tasks were done.</li> <li>-Finish the remainder of the charting (charting must be completed before clocking out and leaving).</li> <li>-Write out the report sheet on the residents to give to the night shift.</li> <li>-Give the night shift aide report. Hand off the pager and key.</li> </ul> <p>Deep cleaning of the rooms included:</p> <ul style="list-style-type: none"> <li>-Dust the windows sills, blinds, and air conditioning units.</li> <li>-Wipe down the bed frame, dresser, nightstand, and TV.</li> <li>-Clean/straighten drawers and closet.</li> <li>-Straighten up the remainder of the room.</li> <li>-Vacuum the carpet.</li> <li>-Clean the mirror, bathroom counter, shower, and toilet.</li> <li>-Collect all trash from the room.</li> <li>-Gather the resident's laundry.</li> </ul> <p>Cross Reference F689</p> <p>The facility failed to ensure adequate supervision for a resident at risk for elopement.</p> <p>Cross Reference F677</p> <p>The facility failed to ensure Activities of Daily Living were provided.</p> <p>This Citation relates to Complaint IN00461158.</p> <p>3.1-17(a)</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, record review and interview, the facility failed to ensure sufficient nursing staff were always available to provide personal care and safety for residents reviewed for staffing. This deficiency had the potential to affect 66 of 66 residents residing in the facility.</p> <p>Findings include:</p> <p>1. The record for Resident B was reviewed on 6/10/25 at 9:48 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, and dementia.</p> <p>The care plan, dated 8/16/24 and revised on 5/23/25, indicated the resident was an elopement risk or wanderer, disoriented to place, impaired safety awareness, and a history of leaving a previous facility unsupervised. The interventions included, but were not limited to: assist in reorientation to the room and facility using verbal cues and reminders; the courtyard gate to be locked with padlock; distract the residents from wandering by offering pleasant diversions, (conversation or offer snack) structured activities, food, conversation, television, and/or book; notify social services and/or the administrator for persistent attempts to leave the building and not respond to redirection; observe for and document wandering and/or exit seeking behavior and attempted diversionary interventions as needed; observe the resident's location with visual checks during rounds and as needed; and put familiar items in the resident's room to assist in identifying room.</p> <p>During an interview, on 6/11/25 at 11:20 a.m., Licensed Practical Nurse (LPN) 4 indicated she was the nurse on duty when the resident went out the gate. She was responsible for [NAME] 6 and 8. At the time the resident left the courtyard she was in Villa 6. There was 1 Certified Nursing Aide (CNA) was in the building, and she was assisting another resident. When she left villa 6, she entered the back entrance of Villa 8. As she entered the unit the CNA was coming out of a resident room. She heard the doorbell ring and when she answered the door the resident was standing there. The resident had a scared look on her face. Management had discontinued all wander guards, and she felt like the wander guards would help alert staff.</p> <p>During an interview, on 6/12/25 at 1:00 p.m., CNA 8 indicated she was assisting another resident to bed, and it took a while to get her in bed. After she assisted the resident to bed, she left the room and saw the nurse entering through the back door. She had been in another villa with those residents. They heard the doorbell ring, and the nurse went to answer the door, and it was Resident B. She walked out to the courtyard and observed the gate unlocked. The gate had a pad lock, but it was hanging on the latch unlocked. She did not know how the gate got unlocked.</p> <p>3. During an interview, on 6/11/25 at 9:55 a.m., the CNA 11 indicated that she was working alone in her position and the Qualified Medication Aide (QMA) 12 was working on medication administration at the moment. The CNA indicated that in one villa there were 4 residents that require two-person physical assistance or the use of the mechanical lift. The CNA indicated the residents were supposed to have two showers a week. Sometimes it was hard to get two to three residents' daily baths done during a shift with all the other duties to complete. The residents who required two staff members for transfers would just receive a partial bed bath.</p> <p>During an observation, on 6/11/25 at 10:00 a.m., Resident 3 was ringing her bell and asked the CNA to get her out of bed. The CNA 11 told the resident that she could not get her up at this time due to being busy doing dishes and it had been a tense morning. The resident still had a gown on and her hair was greasy. She was lying on her back and had not been up out of bed yet.</p> <p>(continued on next page)</p>		

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