

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 09/26/2025
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)
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. (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview and record review, the facility failed to ensure monitoring and flush orders were in place for a resident (Resident D and Resident G) with a midline; failed to ensure documentation was in place for the removal of a midline (Resident D); failed to ensure a pulse was obtained, as ordered, prior to the administration of a hypertensive medication (Resident L); and failed to ensure a blood pressure medication was held, as ordered, for a resident (Resident C) with out of parameter blood pressures for 4 of 6 residents reviewed for quality of care. Findings Include: 1. The clinical record for Resident C was reviewed on 9/23/25 at 1:29 p.m. The resident's diagnosis included, but was not limited to, chronic hypotension. The physician's order, dated 6/18/25, indicated the resident was to receive Midodrine HCl (medication used to increase blood pressure) 5 mg (milligrams) by mouth three times a day at 8:00 a.m., 2:00 p.m. and 10:00 p.m. The medication was to be held for a systolic blood pressure (SBP) greater than 130 or less than 90. The care plan, dated 4/24/25, indicated the resident had a diagnosis of hypotension and to administer medications as ordered. Review of the August 2025 and September 2025 medication administration record indicated the resident was administered the medication with an out of parameter SBP on the following dates and times: -On 8/07/25 at 10:00 p.m., when the resident's SBP was 89.-On 8/15/25 at 8:00 a.m., when the resident's SBP was 137.-On 8/19/25 at 10:00 p.m., when the resident's SBP was 133.-On 8/20/25 at 8:00 a.m., when the resident's SBP was 133.-On 8/25/25 at 8:00 a.m., when the resident's SBP was 132.-On 8/30/25 at 8:00 a.m., when the resident's SBP was 138.-On 9/06/26 at 8:00 a.m. and 2:00 p.m., when the resident's SBP was 163.-On 9/12/25 at 8:00 a.m., when the resident's SBP was 131.-On 9/16/25 at 8:00 a.m. and 2:00 p.m., when the resident's SBP was 147.-On 9/21/25 at 8:00 a.m., when the resident's SBP was 132. During the survey period, between 9/22/25 and 9/26/25, Staff Member 18 indicated if a resident's blood pressure was out of parameters, the medication should have been held. 2. The clinical record for Resident D was reviewed on 9/23/25 at 1:50 p.m. The resident's diagnoses included, but were not limited to, vascular dementia, right sided hemiplegia and hemiparesis and neuromuscular dysfunction of the bladder. On 9/23/25 at 12:10 p.m., the resident was observed sitting up in a scoot chair in the dining room eating dinner. The resident was not observed with a midline in place. The September 2025 medication administration record indicated, on 9/7/25, a midline was to be placed for IV (intravenous) antibiotic therapy. The physician's order, with a start date of 9/8/25, indicated the resident was to receive Piperacillin Sod-Tazobactam (antibiotic for urinary tract infections), 3.375 grams intravenously every 6 hours for 7 days at 12:00 p.m., 6:00 p.m., 12:00 a.m. and 6:00 a.m. The September 2025 medication administration record lacked documentation of the administration of the medication on 9/9/25 at 6:00 a.m., midline flush orders before/after medication administration, monitoring the midline site for infiltration and signs/symptoms of infection and the removal of the midline to ensure the midline catheter tip was in place upon removal. During the survey period, between 9/22/25 and 9/26/25, Staff Member 18 indicated residents with a midline should have flush orders in place prior to and after administration. The nurse should be monitoring the site for signs and symptoms of infection and infiltration every shift. 3. The clinical record for Resident G was reviewed on 9/23/25 at 3:22 p.m. The resident's diagnoses included, but were not limited to, encephalopathy, diabetes and a urinary tract infection. The September 2025 medication administration record indicated on 9/23/25, the resident was to have a midline placed for intravenous antibiotic therapy for a urinary tract infection. On 9/23/25 at 1:10 p.m., the resident was observed with a midline to his right upper arm, dated 9/23/25. The physician's order, dated 9/23/25, indicated the resident was to receive Meropenem, one gram intravenously for a urinary tract infection every 8 hours at 12:00 a.m., 8:00 a.m. and 4:00 p.m. On 9/25/25 at 10:30 a.m., the September 2025 medication administration record indicated the resident had been administered the following doses of the antibiotic medication: -9/24/25 at 12:00 a.m., 8:00 a.m. and 4:00 p.m.-9/25/25 at 12:00 a.m. and 8:00 a.m. The clinical record lacked documentation of the midline flush orders before/after medication administration, monitoring the midline site for infiltration and signs/symptoms of infection from 9/24/25 at 12:00 a.m. through 9/25/25 at 8:00 a.m. 4. The clinical record for Resident L was reviewed on 9/23/25 at 4:18 p.m. The resident's diagnosis included, but was not limited to, hypertension. The current care plan, dated 11/18/21, indicated the resident had a diagnosis of hypertension and to administer medications as ordered. The August 2025 and September 2025 medication administration record indicated the resident was to receive Succinate (medication for high blood pressure) extended release, 50 mg daily. The medication was to be held if the resident's pulse was less than 60 Review of the August 2025 and September 2025 vital signs report lacked</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on interview and record review, the facility failed to ensure a resident's (Resident D) urine output was documented, as ordered, for 1 of 3 residents reviewed for Indwelling catheters. Findings include: The clinical record for Resident D was reviewed on 9/23/25 at 1:50 p.m. The resident's diagnosis included, but was not limited to, neuromuscular dysfunction of the bladder. The physician's order, dated 5/3/25, indicated staff were to monitor the resident's Indwelling catheter output every shift. The August 2025 and September 2025 medication administration records indicated the resident's urine output was not documented on the following dates and shifts:-On 8/07/25 on day shift,-On 8/12/25 on day shift,-On 9/08/25 on night shift,-On 9/16/25 on night shift, and-On 9/18/25 on night shift. During the survey period, between 9/22/25 and 9/26/25, Staff Member 18 indicated physician orders must be followed. On 9/26/25 at 10:39 a.m., the Regional Director of Operations provided a current, undated copy of the document titled Physician Orders. It included, but was not limited to, Policy .It is the policy of the facility to follow the orders of the physician .The facility will follow physician orders to provide essential care to the resident, consistent with the resident's .physical status This Citation relates to Intake 2599540 3.1-41(a)(2)</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>(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>**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 sufficiently staffed to provide adequate care related to medication administration and assistance with daily living for the residents. This deficient practice had the potential to affect 64 of 64 residents residing in the facility. Finding include: 1.a. During the survey period, between 9/22/25 and 9/26/25 at 10:10 a.m., Staff Member 5 was observed passing medications in Villa 2. The staff member indicated the facility was running one aide in each villa and the nurse had 2 [NAME]. Staff Member 5 had only given medications to 5 residents in Villa 2 and 3 residents in Villa 4. It was now after 10:00 a.m. and the medications in villa 2 were due at 8 a.m. Staff Member 5 had to frequently stop the medication administration to assist the aides in providing resident care and in getting the residents up that required two staffs' physical assistance for mobility out of bed. The facility was supposed to have aides that floated between [NAME]; however, they were rarely seen. Most of the time, the floats were pulled due to other staff calling off work. Staffing issues were daily. Staff Member 5 had checked the residents blood sugar levels (BS) but had not yet given insulin and she was out of compliance (within timely medication administration) on the medication pass. Medications should be given either an hour before or an hour after the due time. When Staff Member 5 works 2 [NAME], the medication pass was always out of compliance. Staff member 5 indicated there were 2 to 3 residents in Villa 4 that required two physical staff members for mobility/transfer and 5 residents that required two staff assistance for mobility in Villa 2. During the survey period, between 9/22/25 and 9/26/25 at 10:15 a.m., Staff Member 6 indicated she spends at least 6 hours, sometimes more, on warming, preparing and serving 3 meals a day as well as washing the dishes after each meal. It makes it very hard to provide good quality patient care. If the facility does not assign more than one float, Staff Member 6 cannot even start on her showers until after lunchtime. The nurses have 2 [NAME] each and it does not allow them to help the aides out at all. It was not a safe working environment, for the residents or staff. Staff Member 6 refused to get residents up that requires a full body mechanical lift by herself. The residents have to wait until she can get someone to help her. The residents then get upset because they are still in bed and call their families, who then call Staff Member 6, upset, wanting to know why their loved one was not up yet. They need at least 2 people at all times in the [NAME] to provide care. During the survey period, between 9/22/25 and 9/26/25 at 11:01 a.m., Staff Member 7 indicated the facility was short staffed. She can complete all her patient care assigned but cannot get the assigned deep cleaning and laundry done. She has had residents miss showers as she did not have time to give them. The nurses have 2 [NAME] and when the nurse was at another villa, it was hard to provide care and watch the residents who are a fall risk. The night shift staff were supposed to do laundry and don't because they are short staffed too. The aides spend too much time in the kitchen when the nurse has 2 [NAME]. It makes it very hard to get cleaning, showers and patient care completed. They really need one nurse and one aide per villa and things would go smoother. During the survey period, between 9/22/25 and 9/26/25 at 1:57 p.m., Staff Member 8 indicated the facility was utilizing one nurse and 2 aides per villa on day shift. Then, two weeks after State cleared them, they changed it back to one aide per villa and one nurse for 2 [NAME]. They put on the staffing sheets that there would be aides floating and then they end up not have any. Aides are providing care by themselves because the nurses are in the other villa. If the aide was in a room providing care to a resident, and then a fall alarm goes off, you have to stop what you are doing and go check on the alarm, and then go back and finish. The residents deserve better care than they are getting. The aides are expected to provide care, prepare 3 meals, serve 3 meals, clean the kitchen, clean resident rooms and complete laundry. The management does not help at all. During the survey period, between 9/22/25 and 9/26/25 at 11:26 a.m., Staff Member 9 indicated medications were not given timely and out of compliance (the window of appropriate administration times) when passing medications for 2 [NAME]. During the survey period, between 9/22/25 and 9/26/25 at 11:35 a.m., Staff Member 10 indicated she could never get the assigned cleaning completed or activities done with residents because she did not have time. Patient care came first. The facility needs more staff. The facility was staffing 2 aides in each villa. Last month, in August, it changed to one aide in each villa and the nurses had 2 [NAME] each. They also assigned 2 to 3 aides to float but someone usually called in which took one of the floats away. There were 3 residents in Villa 7 that required the assistance of 2 staff members for transfers and 3 residents in Villa 5. During the survey period, between 9/22/25 and 9/26/25 at 11:47 a.m. Staff Member 11 indicated she could not complete the medication pass for 2 [NAME] timely</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to identify an unresolved quality deficiency which had been cited on previous surveys, and ensure actions were developed and implemented to attempt to correct the deficiency through the quality assessment and assurance (QAA) process, as evidenced by a repeated deficiency for sufficient staffing. This deficient practice had the potential to affect 64 of 64 residents residing in the facility. Findings include: The Quality Assurance and Performance Improvement (QAPI) plan was a general outline of how to set up a QAPI committee and what the committee should do. The QAPI plan was a data driven, proactive approach for improving the quality of life, care and services in long term care. The activities of QAPI involved members at all levels of the organization to identify opportunities for improvement, address gaps in systems or processes, develop and implement and improvement or corrective plan and continuous monitoring of interventions. The following deficiency was cited on this survey and had been cited previously: -F725 Sufficient Staffing was previously cited on Complaint survey completed on 12/31/24. -F725 Sufficient Staffing was previously cited on Complaint survey completed on 3/27/25. -F725 Sufficient Staffing was previously cited on the Annual Survey completed on 6/17/25. Review of the facility QAPI meetings for January 2025 and September 1025 included the following: January 2025 - documented terminations and new hires February 2025 - no documentation March 2025 - documented open positions and terminations April 2025 - documented open positions from the previous month May 2025 - no documentation June 2025 - no documentation July 2025 - open positions documented August 2025 - documented open positions and new hires September 2025 - documented open positions and new hires The QAPI workbook provided lacked documentation of interventions implemented or systemic changes for the continued deficient practice. The QAPI Performance/Peer Review, dated 8/1/25 and updated 9/1/25, indicated the problem was staffing. The corrective actions included, but were not limited to, adjust staffing to ensure CNAs have assistance, monthly rounding, every other month staff interviews, and staffing assignment review. No other information was provided except for the Performance/Peer review Plan document. During an interview, on 9/25/25 at 3:07 p. m., the Regional Director of Operations indicated they had been utilizing one nurse and one aide in each villa. The aides complained that the nurses were not helping them. They then utilized one nurse per 2 [NAME], one aide per villa, and added floats to assist the aides when needed. Review of the staffing sheets indicated the following: Between 8/1/25 through 8/4/25, the facility scheduled one nurse and one aide for each villa. Between 8/5/25 through 8/6/25, the facility scheduled one nurse for 2 [NAME] with 2 aides per villa. Between 8/7/25 through 8/19/25, the facility scheduled one nurse and one aide per villa. On 8/20/25, the facility schedule changed to one nurse for 2 [NAME], one aide per villa with 1 to 3 floats scheduled. On 8/8/25, during night shift starting at 10:00 p.m., there was only one nurse for [NAME] 1, 2, 3 and 4. On 8/23/25, during night shift, there was only one nurse for [NAME] 1, 2, 3 and 4 after the QMA completed the evening medication pass in [NAME] 2 and 4. On 9/8/25, during night shift, there was one nurse for Villa 1 and 3 and the nurse also worked as the aide in Villa 3 due to a call in. On 9/13/25, during night shift, after 10:46 p. m., there was only one nurse for Villa 1, 2, 3 and 4. 3.1-52(b)(2)</p>		