

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 03/30/2026
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the death of a resident (Resident C) was verified by two staff nurses for 1 of 1 resident; and failed to ensure physicians' orders were transcribed, in a timely manner for 1 of 3 residents reviewed for quality of care. Findings include: 1. The clinical record for Resident C was reviewed on [DATE] at 12:27 p.m. The resident's diagnoses included, but were not limited to, nontraumatic chronic subdural hemorrhage (slow accumulation of blood and its breakdown products between the dura mater and arachnoid membrane, often triggered by trivial events, spontaneous atrophy, or anticoagulants), heart failure and dementia (mental decline). The progress note, dated [DATE] at 1:39 a.m., indicated the aide (CNA) informed the nurse that the resident had expired. Upon entering the resident's room, the resident was unresponsive, pale, cold and not breathing. The resident had a do not resuscitate order (DNR). The resident's time of death was 10:22 p.m. The physician and family were informed. The clinical record lacked documentation of a second nurse's assessment of the deceased resident. During the survey period, Staff Member 7 indicated two nurses had to verify the death of a resident with a DNR status. 2. The clinical record for Resident D was reviewed on [DATE] at 1:40 p.m. The resident's diagnoses included, but were not limited to, macular degeneration (common eye disease and leading cause of vision loss in people aged 50 and older) and glaucoma (a group of eye diseases that damage the optic nerve often due to high fluid pressure inside the eye). The optometrist note, dated [DATE] at 11:35 a.m., indicated Resident D was seen on [DATE] with the following medications prescribed on the visit:- Artificial Tears 0.1-0.3% 1 drop in both eyes three times a day for dry eyes-Preservision, AREDS 2 250 mg (milligrams) 90mg-40mg 1 capsule twice daily for macular degeneration-Discontinue Latanoprost eye drops-Start Brimonidine, 0.1% - dorzolamide 2% eye drops, 1 drop to both eyes twice daily for glaucoma. The clinical record lacked documentation of the physician's orders prescribed on [DATE] and not documented until [DATE]. During the survey period, Staff Member 6 indicated orders should be transcribed on the day the physician wrote/ordered them. On [DATE] at 4:05 p.m., the Regional Director of Operations provided a current copy of the document titled Guidelines for Physician Orders-(Following Physician Orders) dated [DATE]. It included, but was not limited to, Policy .It is the policy of the facility to follow the orders of the physician .Procedure .All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received This citation relates to Intakes 2743599, 2960736 and 2964825 410 IAC (Indiana Administrative Code) 16.2-3.1-37</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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to ensure resident's (Resident F and Resident G) had properly functioning motion sensors in place and failed to ensure a resident (Resident F) had a physician's order in place for a motion sensor alarm for 2 of 3 residents reviewed for accidents. Findings include:1.The clinical record for Resident F was reviewed on 3/30/26 at 3:06 p.m. The resident's diagnoses included, but were not limited to, dementia (mental decline) with moderate anxiety and Parkinsonism (neurological disorders that cause movement problems similar to Parkinson's disease).During an observation on 3/30/26 at 10:35 a.m., Resident F was observed sitting up in his wheelchair in his room. There was small alarm box sitting on the handrail just outside and to the left of the resident's door entrance. In the resident's room, to the right of the bathroom door, on the floor was a smaller box. A yellow light was observed to come on with motion present, however, the alarm outside of the door did not come on (in sync), with the motion light. During an interview, on 3/30/26 at 10:37 a.m., the Regional Director of Operations (RDO) indicated the chime on/chime off switch was set in the middle and not all the way up to the on position. The clinical record lacked documentation of a physician's order for the alarm and family notification related to the placement of the alarm. During an interview, during the survey period, Staff Member 9 indicated the motion sensor chime should be on when residents', considered at risk for falls, were in their rooms alone to alert staff of attempted self-transfers. During an interview, during the survey period, Staff Member 6 indicated residents' motion sensors could not be put in place without a physician's order. During an interview, on 3/30/26 at 5:17 p.m., the RDO indicated the resident had been attempting to transfer without assistance and a staff member had placed the motion sensor for the resident's safety. They were currently getting an order for the resident's motion sensor. On 3/30/26 at 2:40 p.m., the RDO provided a current, undated copy of the document titled SAFETY ALARM DEVICES. It included, but was not limited to, Purpose.Safety alarms/devices are utilized when deemed appropriate.Policy.The use of a personal alarm will be on the order of a physician.The resident's family/representative must be informed of and agree to the placement of an alarm.The personal alarm should sound at he Nurse's station if at all possible. 2. The clinical record for Resident G was reviewed on 3/30/26 at 3:43 p.m. The resident's diagnoses included, but were not limited to, dementia, chronic pain, anxiety and lack of coordination. The physician's order, dated 9/5/25, indicated the resident was to have a motion sensor alarm for safety every shift. The physician's order, dated 12/10/25 indicated staff were to check for proper functioning of the resident's motion sensor alarm every shift. The care plan, dated 11/24/25, indicated the resident was at risk for fall and was to have a motion sensor alarm as ordered for safety. During an observation, on 3/30/26 at 10:32 a.m., there was an alarm box sitting on the handrail just outside and to the left of the resident's door entrance. Resident G was observed resting in her bed with her eyes open and she was confused. observed on the floor, to the right of the resident's dresser was a small box. A yellow light was observed to come on with motion in front of the box, however the alarm box outside of the resident's room did not chime. During an interview, on 3/30/26 at 10:37 a.m., the Regional Director of Operations (RDO) indicated the chime on/chime off switch was not on. This citation relates to Intake 2964825 410 IAC (Indiana Administrative Code) 16.2-3.1-45(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 59 of 59 residents residing in the facility. Findings include: 1. On 3/26/26 at 12:33 p.m., the Administrator provided a copy of the March 2026 as worked staffing sheets and on 3/26/26; at 3:01 p.m., the Regional Nurse Consultant provided the March 2026 correlating timecards which indicated the following after review: On 3/14/26, Villa 7 had one nurse and no aide for dayshift On 3/16/26, Villa 3 and Villa 5 shared had one nurse and one aide on night shift On 3/16/26, Villa 1 and Villa 7 shared one nurse and one aide, on night shift, after 10:08 p.m. On 3/18/26, Villa 1 and Villa 7 shared one nurse and one aide, on night shift, after 10:00 p.m. On 3/19/26, Villa 1 and Villa 7 had a nurse scheduled on night shift, that did not clock in until 3/20/26 at 4:53 a.m. On 3/21/26, Villa 2 and Villa 4 shared one nurse and one aide on night shift On 3/22/26, Villa 3 and Villa 5 shared one nurse and one aide on night shift On 3/23/26, Villa 2 and Villa 4 shared one nurse and one aide on night shift: On 3/23/26, Villa 3 and Villa 5 shared one nurse and one aide on night shift On 3/27/26, Villa 2 and Villa 4 shared one nurse and one aide until 9:30 p.m. The facility staffing shift times were from 7:00 a.m. to 7:00 p.m. for day shift and from 7:00 p.m. to 7:00 a.m. on night shift. During the survey period, from March 26 through March 30, Staff Member 7 indicated staffing had been awful in March 2026. They had been told there would be either one nurse and one aide per Villa or two aides per Villa with one nurse for two [NAME]. On 3/14/26, on day shift, Staff Member 8 had to work Villa 7 by herself as she did not have an aide. Staff Member 8 had to prepare the meals, wash dishes, administer medications, complete treatments and provide care to the residents, 9 in total resident's at the time. Staff Member 7 came in around lunch time and stayed for about 3 to 4 hours to help Staff Member 8 get caught up with the residents care. During the survey period, from March 26 through March 30, Staff Member 6 indicated the staff had been told there would be two aides in each Villa and that had not been happening. Recently, on several occasions, there had been one aide and a nurse who shared two [NAME] and the nurse passed medications in both [NAME]. There must be two staff members when using any transfer equipment, so the residents had to wait on the nurse or second aid for transfers. Staff Member 6 indicated medications were administered late due to having to stop the medication pass to assist the aides with the full body mechanical lifts or two staff member assisted resident transfers. During an interview, on 3/26/26 at 1:56 p.m., Resident M indicated he had not received his medication timely. He received his insulin, but all the other medications were late. During an interview, on 3/26/26 at 2:07 p.m., Resident O indicated it was hit and miss with getting your medications timely. The facility usually had one aide and one nurse, and the nurse shared another Villa. During an interview, on 3/27/26 at 11:46 a.m., Resident B indicated her medications were consistently late because they did not have enough staff. When there was one nurse and one aide, and the nurse had to pass medications in two different [NAME], the residents' medications were always late. During an interview, on 3/27/26 at 11:58 a.m., Resident N indicated she did not get her medications timely. She had to wait over an hour for her call light to be answered. This was supposed to be her home. They only had one aide and then one nurse for two [NAME] and the staff would constantly bounced back and forth. Residents were always told by the staff that they don't have enough time, and the residents always had to wait at night because there was not enough staff. During the survey period, from March 26 through March 30, Staff Member 5 indicated staffing was not good. Staff Member 5 not could complete any of the cleaning/laundry tasks daily. Staff Member 5 tried to complete those tasks on Sunday because there were no showers on Sundays. When Staff Member 5 worked, there was only herself and the nurse who had another Villa. Villa 7 had three residents that required full body mechanical lift for transfers and many times, the (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>residents would have to wait to either get up and to be laid down since she had no one to help her when the nurse was in the other Villa. During the survey period, from March 26 through March 30, Staff Member 8 indicated on 3/14/26, she worked Villa 7 without an aide and it was very rough. Staff Member 8 had to get the residents changed and ready for breakfast, do the meal preparation for breakfast, lunch and dinner, wash the dishes, pass the medications and complete treatments as well as the daily charting. Staff Member 7 came in and helped her through lunch. Here lately, there had been multiple times where there was an aide in one Villa and the nurse in the other Villa and they would have to flip flop (walk from one free standing facility building outside to another free standing facility building while no staff were inside either facility building) so the nurse could pass medications. During an interview, on 3/30/26 at 10:44 a.m., Resident K was observed resting in her bed with a full body mechanical lift pad under her. Resident K indicated she has had to wait long periods to get up and to get put back in bed. During the survey period, from March 26 through March 30, Staff Member 3 indicated at 2:00 p.m. on 3/29/26, she was asked to pass the morning medications due at 8:00 a.m. to the residents in Villa 5. 1.a.The clinical record for Resident D was reviewed on 3/27/26 at 1:40 p.m. The resident's diagnoses included, but were not limited to, unilateral osteoarthritis (joint pain, stiffness, and reduced mobility) and right knee pain. The quarterly minimum data set (MDS) assessment, dated 12/23/25, indicated Resident D had intact cognition.The care plan, dated 12/23/25, indicated the resident had a self-care deficit and required a mechanical lift for safe transfers. During an interview, on 3/27/26 at 11:05 a.m., Resident D indicated she was not receiving her medications timely, including her pain medication and night shift was the worst. She used a mechanical lift for transfers, which required two staff members. On the night of 3/23/26, the staff did not get her to bed until midnight because they had one aide in Villa 2, one aide in Villa 4 and one nurse for both Villa 2 and Villa 4. It had happened several times and she preferred to be in bed between 10:00 p.m. and 10:30 p.m., at the latest. On 3/30/26 at 12:06 p.m., Resident D indicated on 3/27/26, on night shift, there was an emergency in Villa 2. She turned her call light on at 8:00 p.m. because she needed to use the restroom. She was told by the aide at that time that she would have to wait for the nurse to help the aide take her to the bathroom. During the wait time, at around 9:00 p.m., Resident D propelled herself, in her wheelchair, to her room door and did not see any staff. Resident L was sitting at the dining room table and told Resident D she had not been able to find anyone so she could get her pain medication and that there was not a single staff member in the Villa. Resident D sat at the table with Resident L for about 5 to 10 minutes and did not see a sole. She wet all over herself because she had to wait over 90 minutes for the nurse to come back and help. At around 9:30 p.m., the aide and nurse assisted her to the bathroom and then put her back in her wheelchair. She did not get her medications until 11:15 p.m. and was not assisted to bed until 11:30 p.m. Resident D's quarterly MDS assessment, dated 12/23/25, indicated the resident had intact cognition. 1.b. The clinical record for Resident E was reviewed on 3/30/26 at 2:45 p.m. The resident's diagnoses included, but were not limited to, diabetes (chronic high blood sugar levels, resulting from the body's inability to produce enough insulin or use it effectively) and morbid obesity. The quarterly MDS assessment, dated 1/28/26, indicated Resident E had intact cognition. During an interview, on 3/27/26 at 11:18 a.m., Resident E indicated he did not always get his medication on time. There were just not enough staff. He had the staff put him to bed around 6:30 p.m., at shift change, because there were two aides at that time. He really doesn't like going to bed that early but did not want to take a chance on having to be up after 10:00 p.m. or 11:00 p.m. to get to bed. The facility cannot seem to keep help and the good ones are leaving because they work them to death. There had never been two aides working in his Villa on day shift, only one and the nurse had two [NAME].During an interview, on 3/30/26 at 11:44 a.m., Resident E requested to speak to surveyor. Upon entrance to the resident's room, Resident E was visibly upset. He indicated on 3/27/26, on night shift, there was no nurse or aide in the Villa with the residents. He turned his call light on at 8:40 p.m. No one answered his call light until 9:20 p.m. He asked the aide where she had been, and she told him she was in another Villa. He was not sure how (continued on next page)</p>		

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The physician's order, dated 1/21/26, indicated the resident was to receive Insulin Glargine (long-acting insulin) 20 units subcutaneously between 8:00 p.m. and 11:00 p.m. Review of the March 2026 medication administration record (MAR) indicated the resident received the insulin late on the following dates and times:-3/04/26 administered on 3/05/26 at 12:03 a.m.-3/07/26 administered on 3/08/26 at 12:26 a.m.-3/08/26 administered on 3/09/26 at 12:42 a.m.-3/10/26 administered on 3/11/26 at 12:34 a.m.-3/15/26 administered on 3/16/26 at 12:29 a.m.-3/17/26 administered on 3/18/26 at 12:36 a.m.-3/22/26 administered on 3/23/26 at 4:46 a.m.-3/23/26 administered on 3/24/26 at 12:13 a.m.-3/25/26 administered on 3/26/26 at 2:38 a.m.</p> <p>1.c. The clinical record for Resident H was reviewed on 3/30/26 at 3:58 p.m. The resident's diagnoses included, but were not limited to, diabetes, acquired absence of the left foot and a right below knee amputation. The Medicare 5-day MDS assessment, dated 2/18/26, indicated Resident H had intact cognition. During an interview, on 3/30/26 at 10:55 a.m., Resident H indicated she has had to wait to get out of bed and be put back into the bed because the Villa only had one aide and the full body mechanical lift required two staff for transfers. She has had to wait for her medication because the nurse was busy in another Villa since she had two [NAME] to pass medications in. The care plan, dated 2/12/26, indicated the resident required a full body mechanical lift for safe transfers and would be transferred with two staffs' assistance when using the full body mechanical lift or when using a sit-to-stand lift. The care plan, dated 2/12/26, indicated the resident had diabetes and medications would be provided as ordered. The physician's order, dated 2/12/26, indicated the resident was to receive Insulin Lispro (fast-acting insulin), 12 units subcutaneously before meals for diabetes at 7:00 a.m., 11:00 a.m. and 4:00 p.m. Review of the March 2026 MAR indicated the insulin was administered late on the following dates and times:-3/01/26, 11:00 a.m. dose was administered at 12:43 p.m.-3/02/26, 11:00 a.m. dose administered at 12:09 and the 4:00 p.m. dose administered at 5:13 p.m.-3/03/26, 7:00 a.m. dose administered at 8:43 a.m.-3/04/26, 7:00 a.m. dose administered at 8:55 a.m.-3/04/26, 11:00 a.m. dose administered at 2:23 p.m.-3/05/26, 7:00 a.m. dose administered at 8:22 a.m.-3/07/26, 7:00 a.m. dose administered at 9:05 a.m. and the 11:00 a.m. dose administered at 12:46 p.m.-3/08/26, 7:00 a.m. dose administered at 8:49 a.m.-3/10/26, 7:00 a.m. dose administered at 9:33 a.m., 11:00 a.m. dose administered at 12:44 p.m., and the 4:00 p.m. dose administered at 5:33 p.m.-3/15/26, 11:00 a.m. dose administered at 12:53 p.m.-3/18/26, 7:00 a.m. dose administered at 8:41 a.m.-3/22/26, 4:00 p.m. dose administered at 6:51 p.m.-3/23/26, 11:00 a.m. dose administered at 12:47 p.m. and 4:00 p.m. dose administered at 5:43 p.m.-3/27/26, 11:00 a.m. dose administered at 12:24 p.m.-3/30/26, 11:00 a.m. dose administered at 1:03 p.m. 1.d. The clinical record for Resident L was reviewed on 3/30/26 at 4:24 p.m. The resident's diagnosis included, but was not limited to, diabetes. The annual MDS assessment, dated 1/5/26, indicated Resident L had intact cognition. During an interview, on 3/30/26 at 11:55 a.m., Resident L indicated on 3/27/26, on the night shift, between 8:15 p.m. and 9:15 p.m., there was no staff members in the Villa. She sat out at the dining room table and waited because she wanted to get her pain pill. There were other residents looking for help too prior to someone coming back to the Villa. Every time we needed something, there was some sort of crisis in Villa 4. She was here at the facility for the management of her pain and management for her diabetes. The facility did not do either because she cannot get her pain medication or diabetic medication on time. The care plan, dated 1/7/26, indicated the resident had diabetes and to provide medications as ordered. The physician's order, dated 7/25/25, indicated the resident was to receive Lantus (long-acting insulin), 10 units subcutaneously in the morning at 9:00 a.m. for hyperglycemia. The March 2026 MAR indicated the resident received the insulin late on the following dates and times:-3/02/26 at 11:15 a.m.-3/03/26 at 11:11 a.m.-3/06/26 at 11:02 a.m.-3/09/26 at 11:32</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents received their medication timely within an hour before or after the prescribe time for 3 of 3 resident reviewed for pharmacy services. (Resident E, Resident H, and Resident L) Findings include: 1. The clinical record for Resident E was reviewed on 3/30/26 at 2:45 p.m. The resident's diagnosis included, but was not limited to, diabetes (chronic high blood sugar levels, resulting from the body's inability to produce enough insulin or use it effectively). The quarterly minimum data set (MDS) assessment, dated 1/28/26, indicated Resident E had intact cognition. The care plan, dated 1/27/26, indicated the resident had diabetes and would be provided with medications as ordered. The physician's order, dated 1/21/26, indicated the resident was to receive Insulin Glargine (long-acting insulin) 20 units subcutaneously between 8:00 p.m. and 11:00 p.m. Review of the March 2026 medication administration record (MAR) indicated the resident received the insulin over one hour past the scheduled medication administration time of 8:00 to 11:00 p.m. on the following dates and times:-On 3/04/26, the resident's insulin was administered on 3/05/26 at 12:03 a.m.-On 3/07/26, the resident's insulin was administered on 3/08/26 at 12:26 a.m.-On 3/08/26, the resident's insulin was administered on 3/09/26 at 12:42 a.m.-On 3/10/26, the resident's insulin was administered on 3/11/26 at 12:34 a.m.-On 3/15/26, the resident's insulin was administered on 3/16/26 at 12:29 a.m.-On 3/17/26, the resident's insulin was administered on 3/18/26 at 12:36 a.m.-On 3/22/26, the resident's insulin was administered on 3/23/26 at 4:46 a.m.-On 3/23/26, the resident's insulin was administered on 3/24/26 at 12:13 a.m.-On 3/25/26, the resident's insulin was administered on 3/26/26 at 2:38 a.m. During an interview, on 3/27/26 at 11:18 a.m., Resident E indicated he did not always get his medication on time. 2. The clinical record for Resident H was reviewed on 3/30/26 at 3:58 p.m. The resident's diagnoses included, but were not limited to, diabetes, acquired absence of the left foot and a right below knee amputation. The Medicare 5-day MDS assessment, dated 2/18/26, indicated Resident H had intact cognition. During an interview, on 3/30/26 at 10:55 a.m., Resident H indicated she had to wait for her medication because the nurse was busy in another Villa since she had two [NAME] to pass medications in. The care plan, dated 2/12/26, indicated the resident had diabetes and medications would be provided as ordered. The physician's order, dated 2/12/26, indicated the resident was to receive Insulin Lispro (fast-acting insulin), 12 units subcutaneously before meals for diabetes at 7:00 a.m., 11:00 a.m. and 4:00 p.m. Review of the March 2026 MAR indicated the insulin was administered over one hour past the scheduled medication dose time on the following dates and times:-On 3/01/26, the resident's 11:00 a.m. insulin dose was administered at 12:43 p.m.-On 3/02/26, the resident's 11:00 a.m. insulin dose was administered at 12:09 and the 4:00 p.m. insulin dose was administered at 5:13 p.m.-On 3/03/26, the resident's 7:00 a.m. insulin dose was administered at 8:43 a.m.-On 3/04/26, the resident's 7:00 a.m. insulin dose was administered at 8:55 a.m.-On 3/04/26, the resident's 11:00 a.m. insulin dose was administered at 2:23 p.m.-On 3/05/26, the resident's 7:00 a.m. insulin dose was administered at 8:22 a.m.-On 3/07/26, the resident's 7:00 a.m. insulin dose was administered at 9:05 a.m. and the 11:00 a.m. insulin dose was administered at 12:46 p.m.-On 3/08/26, the resident's 7:00 a.m. insulin dose was administered at 8:49 a.m.-On 3/10/26, the resident's 7:00 a.m. insulin dose was administered at 9:33 a.m., 11:00 a.m. insulin dose was administered at 12:44 p.m., and the 4:00 p.m. insulin dose was administered at 5:33 p.m.-On 3/15/26, the resident's 11:00 a.m. insulin dose was administered at 12:53 p.m.-On 3/18/26, the resident's 7:00 a.m. insulin dose was administered at 8:41 a.m.-On 3/22/26, the resident's 4:00 p.m. insulin dose was administered at 6:51 p.m.-On 3/23/26, the resident's 11:00 a.m. insulin dose was administered at 12:47 p.m. and 4:00 p.m. insulin dose was administered at 5:43 p.m.-On 3/27/26, the resident's 11:00 a.m. insulin dose was administered at 12:24 p.m.-On 3/30/26, the resident's 11:00 a.m. insulin dose (continued on next page)</p>		

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 03/30/2026
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>was administered at 1:03 p.m. 3. The clinical record for Resident L was reviewed on 3/30/26 at 4:24 p.m. The resident's diagnosis included, but was not limited to, diabetes. The annual MDS assessment, dated 1/5/26, indicated Resident L had intact cognition. The care plan, dated 1/7/26, indicated the resident had diabetes and to provide medications as ordered. The physician's order, dated 7/25/25, indicated the resident was to receive Lantus (long-acting insulin), 10 units subcutaneously in the morning at 9:00 a.m. for hyperglycemia. The March 2026 MAR indicated the resident received the insulin over one hour past the scheduled medication dose on the following dates and times:-On 3/02/26, the resident's 9:00 a.m. insulin dose was administered at 11:15 a.m.-On 3/03/26, the resident's 9:00 a.m. insulin dose was administered at 11:11 a.m.-On 3/06/26, the resident's 9:00 a.m. insulin dose was administered at 11:02 a.m.-On 3/09/26, the resident's 9:00 a.m. insulin dose was administered at 11:32 a.m.-On 3/10/26, the resident's 9:00 a.m. insulin dose was administered at 11:02 a.m.-On 3/12/26, the resident's 9:00 a.m. insulin dose was administered at 10:58 a.m.-On 3/13/26, the resident's 9:00 a.m. insulin dose was administered at 11:19 a.m.-On 3/16/26, the resident's 9:00 a.m. insulin dose was administered at 11:16 a.m.-On 3/17/26, the resident's 9:00 a.m. insulin dose was administered at 10:20 a.m.-On 3/19/26, the resident's 9:00 a.m. insulin dose was administered at 10:57 a.m.-On 3/21/26, the resident's 9:00 a.m. insulin dose was administered at 10:18 a.m.-On 3/23/26, the resident's 9:00 a.m. insulin dose was administered at 11:13 a.m.-On 3/24/26, the resident's 9:00 a.m. insulin dose was administered at 11:41 a.m. The physician's order, dated 8/7/25, indicated the resident was to receive Humalog (short-acting insulin) per sliding scale before meals and at bedtime at 7:30 a.m., 11:30 a.m., 4:30 p.m. and 10:00 p.m. The March 2026 MAR indicated the resident received the insulin over one hour past the scheduled medication time on the following dates and times:-On 3/01/26, the resident's 4:30 p.m. insulin dose was administered at 6:03 p.m.-On 3/02/26, the resident's 11:30 a.m. insulin dose was administered at 12:40 p.m.-On 3/03/26, the resident's 11:30 a.m. insulin dose was administered at 12:57 p.m.-On 3/04/26, the resident's 10:00 p.m. insulin dose was administered at 11:52 p.m.-On 3/07/26, the resident's 10:00 p.m. insulin dose was administered on 3/8/26 at 12:25 a.m.-On 3/09/26, the resident's 7:30 a.m. insulin dose was administered at 10:50 a.m. and the 11:30 a.m. dose was administered at 12:53 p.m.-On 3/10/26, the resident's 11:30 a.m. insulin dose was administered at 1:02 p.m.-On 3/12/26, the resident's 7:30 a.m. insulin dose was administered at 10:56 a.m.-On 3/15/25, the resident's 10:00 p.m. insulin dose was administered on 3/16/26 at 12:28 a.m.-On 3/16/26, the resident's 11:30 a.m. insulin dose was administered at 12:46 p.m.-On 3/19/26, the resident's 4:30 p.m. insulin dose was administered at 5:45 p.m.-On 3/21/26, the resident's 4:30 p.m. insulin dose was administered at 6:23 p.m.-On 3/24/26, the resident's 11:30 a.m. insulin dose was administered at 1:07 p.m.-On 3/25/26, the resident's 4:30 p.m. insulin dose was administered at 6:40 p.m. During an interview, on 3/30/26 at 11:55 a.m., Resident L indicated she was here at the facility for the management of her pain and management for her diabetes. The facility did not do either because she cannot get her pain medication or diabetic medication on time. During the survey period, from March 26 through March 30, Staff Member 6 indicated medications were administered late due to having to stop the medication pass to assist the aides with the full body mechanical lifts, two staff member assisted resident transfers, or cover two Villa's (separate free standing buildings with going outside to get from one Villa to another while trading places with the aid in the other Villa). On 3/30/26 at 4:22 p.m., the Regional Director of Operations provided a current copy of the document titled Medication Administration Policy Guideline dated 1/25/19. It included, but was not limited to, Policy.Medications are administered as prescribed, in accordance with good nursing principles and practices.Procedure.The resident's MAR is initialed by the person administering the medication. This Citation relates to Intakes 7243599, 2960736 and 2964825 410 IAC (Indiana Administrative Code) 16.2-3.1-25(a)</p>		

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 03/30/2026
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on interview and record review, the facility failed to ensure medication administration records coincided with the administration of narcotic pain medication for 3 of 4 residents reviewed for medical records. (Resident E, Resident H and Resident L) Findings include: 1. The clinical record for Resident E was reviewed on 3/30/26 at 2:45 p.m. The resident's diagnoses included, but were not limited to, osteoarthritis (joint pain, stiffness, and reduced mobility), lymphedema (chronic, localized swelling caused by a buildup of lymph fluid in tissues), diabetes (chronic high blood sugar levels) and depression. The physician's order, dated 1/21/26, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 5-325 mg (milligrams) every 6 hours as needed (PRN) for pain. The March 2026 controlled drug record indicated the resident received the narcotic pain medication on the following dates and times: 3/01/26 at 9:10 p.m., 3/02/26 at 9:00 p.m., 3/05/26 at 9:30 p.m., 3/06/26 at 9:00 p.m., 3/07/26 at 10:13 p.m., 3/08/26 at 8:00 p.m., 3/12/26 at 9:45 p.m., 3/13/26 at 9:00 p.m., 3/14/26 at 8:00 p.m., 3/15/26 at 9:10 p.m., 3/16/26 at 10:30 p.m., 3/18/26 at 9:26 p.m., 3/19/26 at 10:05 p.m., 3/20/26 at 10:26 p.m., 3/21/26 at 8:07 p.m., 3/22/26 at 8:00 p.m., 3/23/26 at 8:00 p.m., 3/25/26 at 11:00 p.m., and 3/26/26 at 10:52 p.m. The March 2026 medication administration record (MAR) lacked documentation of the administration of the above narcotic pain medication. During the survey period, from March 26 through March 30, Staff Member 6 indicated when an as needed pain medication was administered, the medication administration record should be signed off by the nurse. On 3/30/26 at 4:22 p.m., the Regional Director of Operations provided a current copy of the document titled Medication Administration Policy Guideline dated 1/25/19. It included, but was not limited to, Policy.Medications are administered as prescribed, in accordance with good nursing principles and practices.Procedure.The resident's MAR is initiated by the person administering the medication. 2. The clinical record for Resident H was reviewed on 3/30/26 at 3:58 p.m. The resident's diagnoses included, but were not limited to, diabetes and depression. The physician's order, dated 3/21/26, indicated the resident was to receive Tramadol (narcotic pain medication) 50 mg every 6 hours as needed for pain. The March 2025 controlled drug record indicated the resident received the medication on the following dates and times: 3/23/26 at 9:00 a.m., 3/24/26 at 3:40 p.m. and 9:15 p.m., 3/26/26 at 8:00 p.m., 3/28/26 at 8:00 a.m., and 3/29/26 at 8:00 a.m. The March 2026 MAR lacked documentation of the administration of the above narcotic pain medications. 3. The clinical record for Resident L was reviewed on 3/30/26 at 4:24 p.m. The resident's diagnoses included, but were not limited to, diabetes, depression and fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain, fatigue, sleep disturbances, and cognitive issues). The physician's order, dated 5/21/25, indicated the resident was to receive Hydrocodone-5-325 mg every 4 hours as needed for pain. The March 2026 controlled drug record indicated the resident received the medication on the following dates and times: 3/01/26 at 12:15 p.m., 4:30 p.m. and 8:42 p.m.; 3/02/26 at 10:00 a.m., 2:00 p.m. and 6:00 p.m.; 3/03/26 at 10:00 a.m. and 2:00 p.m.; 3/05/26 at 11:40 a.m. and 9:00 p.m.; 3/06/26 at 12:00 a.m. and 9:00 p.m.; 3/07/26 at 8:00 a.m., 12:15 p.m. and 8:54 p.m.; 3/08/26 at 8:00 a.m., 1:00 p.m. and 8:00 p.m.; 3/09/26 at 10:00 a.m., 2:00 p.m. and 6:00 p.m.; 3/10/26 at 10:00 a.m., 2:00 p.m. and 6:00 p.m.; 3/11/26 at 5:15 p.m. and 10:15 p.m.; 3/12/26 at 10:00 a.m. and 2:00 p.m.; 3/13/26 at 10:00 a.m., 2:00 p.m. and 10:30 p.m.; 3/14/26 at 9:00 a.m., 1:00 p.m. and 5:00 p.m.; 3/15/26 at 9:27 p.m.; 3/16/26 at 10:00 a.m., 2:00 p.m. and 6:00 p.m.; 3/17/26 at 10:00 a.m., 2:00 p.m., 6:00 p.m. and 10:00 p.m.; 3/18/26 at 5:45 p.m. at 10:40 p.m.; 3/19/26 at 10:00 a.m., 2:00 p.m., 6:00 p.m. and 9:58 p.m.; 3/20/26 at 5:00 p.m. and 9:33 p.m.; 3/21/26 at 8:37 p.m.; 3/22/26 at 10:00 p.m.; 3/23/26 at 10:00 a.m., 2:00 p.m., 6:00 p.m. and 10:00 p.m.; 3/24/26 at 10:00 a.m., 2:00 p.m. and 6:00 p.m.; 3/25/26 at 12:33 p.m. and 11:15 p.m.; 3/26/26 at 9:00 a.m. and 2:00 p.m.; 3/27/26 at 8:30 p.m.; 3/28/26 at 4:00 a.m., and 4:30 p.m. and 10:00 p.m. The March 2026 MAR lacked documentation of the administration of the above narcotic pain medications. This citation relates to Intake 2743599 410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(2)</p>		