

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to notify the physician and the resident's responsible party related to elevated blood sugar levels for 1 of 3 residents reviewed for notifications. (Resident 33)</p> <p>Findings included:</p> <p>The clinical record for Resident 33 was reviewed on 6/12/25 at 10:30 am. The resident's diagnoses included, but were not limited to atrial fibrillation, hypertension, edema, diabetes, right ankle wound, and unspecified dementia.</p> <p>The physician's order, dated 10/14/24, indicated the resident was prescribed HumaLOG KwikPen Subcutaneous Solution (Insulin) Lispro with instructions for a sliding scale subcutaneously before meals and at bedtime. The sliding scale was as follows: Inject as per sliding scale: if resident's blood sugar (BS) level was 150 to 200 staff were to administer 2 units (U); 201 to 250, give 4U; 251 to 300, give 6U; 301 to 350, give 8U; 351 to 400, give 10U; for a BS greater than 400 give 10 units and call the physician.</p> <p>The physician's order, dated 10/14/24, indicated the resident was prescribed HumaLOG KwikPen Subcutaneous Solution with instruction to Inject 5 unit subcutaneously two times a day and to hold for a glucose reading less than 100.</p> <p>During an interview, on 6/12/24 at 01:33 p.m., RN (Registered Nurse) 13 indicated the provider and family should be notified immediately if the resident's blood glucose values were below the critical low or high range.</p> <p>During an interview, on 6/12/25 at 10:30 a.m., LPN 5 indicated if the residents' BS was greater than 400 the physician needed to be notified and then if new orders were received the family needed to be notified. Any change of condition in the resident would warrant a call to the provider and the family, then the nurse would document the change and who was notified.</p> <p>During a record review of the last 30 days, on 6/13/25 at 11:45 a.m., the review indicated that the resident had the following blood sugars greater than 400(mg/dL) milligrams per deciliter.</p> <ul style="list-style-type: none"> - On 6/11/2025 at 3:37p.m., the resident's blood sugar level was 421 mg/dL. - On 6/10/2025 at 6:54p.m., the resident's blood sugar level was 445 mg/dL. <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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 6/8/2025 at 5:18 p.m., the resident's blood sugar level was 520 mg/dL.</p> <p>- On 6/1/2025 at 5:53 p.m., the resident's blood sugar level was 400 mg/dL.</p> <p>- On 5/13/2025 at 7:56 a.m., the resident's blood sugar level was 418 mg/dL.</p> <p>The resident's record lacked documentation to indicate the physician or responsible party were notified of the resident's elevated blood glucose levels.</p> <p>Guidelines for notification of change in Resident's condition/status/treatment dated 6/29/24 was provided by the corporate nursing director on 6/13/25. The guidelines included, but was not limited to, .The objective of the notifications to the required parties .Nursing and other care staff are educated to identify changes in a resident's condition .Examples of situations .any critical lab value .</p> <p>3.1-5(a)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During a confidential interview, between 6/12/25 and 6/16/25, Staff 100 indicated there was only one CNA in each building. If a resident required the use of a full body mechanical lift, sit to stand, or required two staff members assistance for mobility/transfers or toileting, then the nurse would be called to come over and help. Sometimes there was a wait until the nurse was free to come over. Some days were harder than others.</p> <p>During an confidential interview, between 6/9/25 and 6/16/25, Staff 101 indicated some [NAME] were harder because there were some residents who required a lot of care. There were five out of ten residents who required the use of a full body mechanical lift to get up or be put back to bed. The lift would require the assistance of two staff members. The nurses were usually called from another villa to help the CNA do the lift, watched the villa while the CNA toileted residents, or was giving showers. Sometimes there was a wait until staff were finished what they were doing before coming over to help the CNA.</p> <p>During a confidential interview, between 6/9/25 to 6/16/25, Staff 102 indicated there were aides who floated between the buildings to help the 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. It was a struggle to get everything done by end of shift. Truthfully, the CNAs had too many tasks to do. The CNAs had to cook the meals sent over, serve the residents and clean up, cleaning the rooms, vacuuming and doing laundry, resident care, toileting, ADL's (Activities of Daily Living) on those that needed help and showers. Staff were supposed to also do the activities. A lot of times a resident would suddenly tell staff they needed to go to the bathroom while in the middle of serving. The CNA would have to stop, take them to the bathroom, then come back and sanitize and re-glove and re-heat the meal and then finally serve the residents. Staff G indicated that at times, staff had to put off a resident's shower because there was no time.</p> <p>During a confidential interview, between 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 that floated between the [NAME] to help out. Having a floater really helped the CNA in doing care. The aide really struggled to get her work done.</p> <p>During a confidential interview, between 6/9/25 and 6/16/25, Staff 104 indicated there was only one CNA for each villa. At times, they could not get all of their tasks done in caring for the residents although she tried really hard. It got tough to get to all of the residents, do their care, toilet or do showers. Staff J indicated they were not able to do the activities that were scheduled. If a resident required two staff members assistance or the use of a full body mechanical lift, they would have to call the nurse or another villa to get someone to come over and help. 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 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 shift CNAs because the night shift only got certain people up before they left. Then the day shift CNA had to get the rest of the residents up along with all their other duties.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The current facility policy, dated 09/21/23 titled, Guidelines for Bathing, which was provided by nursing staff, indicated the following: Policy: To cleanse the skin and to promote circulation .Verify bath schedule or need . never leave a resident in tub or shower room unattended .</p> <p>3.1-38(a)(3)</p> <p>3.1-38(a)(2)(A)</p> <p>3.1-38(a)(2)(B)</p> <p>3.1-38(A)(2)(C)</p> <p>Based on observation, record review and interview, the facility failed to ensure ADL's (Activities of Daily Living) were provided for 3 of 21 residents reviewed for ADL care. (Residents 3, 10, and 41)</p> <p>Findings include:</p> <p>1. During an observation, on 6/11/25 at 10:00 a.m., Resident 3 turned on her call light and asked Certified Nurse Aide (CNA) 11 to assist her out of the bed. The CNA told the resident she could not get her up because she was busy washing the dishes and it had been a tense morning. Resident 3 still had a gown on, and her hair was unkept.</p> <p>During an observation, on 6/11/25 at 10:10 a.m., Resident 3 turned on her call light and asked CNA 11 to provide her with assistance getting out of bed. CNA 11 informed the resident that she could not get her up because she was busy putting the groceries away.</p> <p>During an observation, on 6/11/25 at 10:30 a.m., the Qualified Medication Aide (QMA) 12 indicated I don't even know who [Resident 3] is. or I could help.</p> <p>During an observation, on 6/11/25 at 12:50 p.m., Resident 3 remained in bed with her gown on and lying on her back. The resident's hair was still unkept and appeared unwashed. The resident indicated she had not gotten cleaned up or provided assistance out of the bed.</p> <p>During an observation, on 6/12/25 9:30 a.m., Resident 3 was lying in bed with her gown from yesterday on and lying on her back, her hair remained unkept.</p> <p>The record for Resident 3 was reviewed on 6/12/25 at 11:30 am. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus without complications, nontraumatic subarachnoid hemorrhage, chronic respiratory failure, muscle weakness, cognitive social or emotional deficit following nontraumatic intracerebral hemorrhage, dysphagia, neuromuscular dysfunction of bladder, and contracture of the right and left ankle.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 4/17/25, indicated the resident was moderately cognitively impaired, and required maximal staff assistance with transfers, bed mobility, personal hygiene and bathing.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The care plan, dated 6/13/24 and revised on 2/18/25, indicated the resident had an ADL self-care performance deficit related to activity intolerance, impaired balance, musculoskeletal impairment, shortness of breath, and stroke. The interventions included, but were not limited to, a mechanical lift was indicated for transfers with assistance of two staff members, required staff assistance with turning and repositioning as needed.</p> <p>The review of the May and June task report indicated the following:</p> <ul style="list-style-type: none"> - On 5/15/25, the record lacked documentation the resident received a shower or her hair washed. - On 5/19/25, the record lacked documentation the resident received a shower or her hair washed. - On 5/29/25, the record lacked documentation the resident received a shower or her hair washed. - On 6/2/25, the record lacked documentation the resident received a shower or her hair washed. - On 6/9/25, the record lacked documentation the resident received a shower or her hair washed. <p>The resident did not refuse a shower or having her hair wash during the months of May and June.</p> <p>The nurse's note, dated 5/17/2025 at 10:17 a.m., indicated the resident was banging on the bedside table and was yelling at 7:15 a.m. The resident indicated that she wanted up out of bed. Staff members told the resident they could not get her up, but would get her up as soon as possible. A CNA took the resident her breakfast and the resident threw the dishes on the floor. A snack and drink was offered to the resident as well as a change in position in bed until staff were able to get her up out of bed, and she denied that offer and continued with behaviors.</p> <p>During an interview, on 6/11/25 at 9:55 a.m., CNA 11 indicated that she was working alone in her position and QMA 12 was administering medication to the residents. CNA 11 indicated in the villa there were four residents that require the assistance of two staff members for assistance or the use of a mechanical lift. 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 they were required to complete. The residents who required two staff members for transfers would receive a partial bed bath instead of a shower.</p> <p>2. The record for Resident 41 was reviewed on 6/10/25 at 8:30 a.m. The residents' diagnoses included, but were not limited to Alzheimer's disease, Parkinson's disease with dyskinesia, chronic lymphocytic leukemia of b-cell type not having achieved remission, osteoarthritis, and presence of artificial hip joint.</p> <p>The Quarterly MDS assessment, dated 5/14 /25, indicated the resident's cognition was moderately impaired and the resident required substantial or maximum physical assistance for ADL care.</p> <p>The care plan, dated 1/27/25, indicated the resident had a self-care deficit related to needed assistance with ADLs to maintain the highest possible level or functioning. The interventions included, but were not limited to, mechanical lift with 2 participants for transfers, total assistance and one staff for bathing and dressing, required total assistance and one staff participant for personal hygiene and oral care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview, on 6/10/25 at 1:16 p.m., Resident 41's family member indicated they don't have enough people here. She had visited the villa for over two hours on one occasion and did not see a single staff member during that length of time.</p> <p>The review of the May and June task sheet for the residents indicated Resident 41 did not have her hair washed in the months of May and June.</p> <p>During an observation, on 6/12/25 at 10:50 a.m., Resident 41 was observed lying in bed. The resident's room had a strong urine and body odor. The CNA entered the resident's room and indicated the resident's bed was urine soaked and she had to change the resident's gown, sheets, and underpad.</p> <p>3.The record for Resident 10 was reviewed on 6/12/25 at 9:30 am. The resident's diagnoses included, but were not limited to, esophageal obstruction, epilepsy, moderate protein-calorie malnutrition, generalized anxiety disorder, muscle weakness, difficulty in walking, unspecified dementia with mood disturbance, and dysphagia.</p> <p>The Quarterly MDS assessment, dated 4/10/25, indicated the resident's cognition was moderately cognitively impaired and the resident required maximal staff assistance with personal hygiene, bathing, and dressing.</p> <p>Review of the May and June task report, indicated the resident was to receive a shower on 5/24/25, and 5/31/25. The resident received a partial bath (the face, hands, underarms, and genital area) on one occasion on 5/28/25. No other showers or baths were documented for May and June.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. During random observations of Villa 6, between 6/9/25 and 6/11/25, Residents 6, 7, and 20 were in a recliner asleep in the common area. No activities were going on either by the Activity Director or the CNAs.</p> <p>During random observations of Villa 2, between 6/9/25 and 6/11/25, Residents 19, 49, and 3 were in the dining room area just sitting at the table sipping coffee. No activities were going on either by the Activity Director or the CNAs.</p> <p>Resident 1 was observed in her recliner in the common area during random observations, between 6/9/25 and 6/12/25. The resident was usually asleep or just looking around. No activities were occurring on any of the observations.</p> <p>An Activities Care Plan, with a start date of 5/20/22 and a revision date of 2/2/25, indicated Resident 1 had been sitting in a recliner in the day room for long periods of time. The resident indicated she was open to attending all group activities as she was a very social person, but needed to be invited and encouraged to attend due to dementia. The goal was for her to participate in activities of interest in both her and other [NAME] three times a week. The interventions included, but were not limited to, encourage her to participate in all activities; socialize with staff and others during meals and care; and staff to assist her to all activities of interest.</p> <p>During a confidential interview, between on 6/9/25 and 6/16/25, Staff 102 indicated that truthfully, the CNAs had too many tasks to do. The CNAs' had to cook the meals sent over, serve the residents meals and cleaning up, cleaning the rooms, vacuuming and doing laundry, resident care, toileting, ADLs on those that needed help and showers, and the CNAs were expected to do the activities. The Activity Director came in every morning and dropped off some coloring pages and the Daily Chronicle for the residents. She then left the villa. Most of the time, the coloring pages went into the trash as none of the residents wanted to color. If no one was up or out of their room when they came to the villa, they would leave and go to another villa. She did not wait for any of the residents to come nor go around and let them know what the activity was. The activities really were not occurring according to the calendar. Staff 102 indicated they would love to have the time to do the ladies nails, but that was also something activities could do with the residents, but they didn't. The ladies loved it when they got their nails and hair done. One time in Villa 5 the activity staff took the residents outside on the patio, had some drinks for them and they listened to the radio. It was great the residents had fun. But it had not been done since a long time ago.</p> <p>During a confidential interview, between 6/9/25 and 6/16/25, Staff 104 indicated there was only one CNA for each villa and the Qualified Medication Aide(QMA) or the nurse would help if they could. Doing activities was also one of the duties the aide was expected to do. Although she made sure to interact with her residents every day, she really was not able to do the activities that were scheduled.</p> <p>During a confidential interview, between 6/9/25 and 6/16/25, Staff 105 indicated she tried to do hair and nails for the ladies one time a week if able, but was unable to do any of the other activities</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview with the Activity Director, on 6/12/25 at 10:25 a.m., she indicated she was hoping for an activity assistant, but was not sure she would get one. She indicated the morning activity was to have coffee and the daily chronicle to read in the mornings and watched TV news. She would leave coloring pages and a newsletter in each villa for the residents to do. Then, in the afternoon was her big activity and she would go to each villa and spend 30 minutes for activities every day.</p> <p>During random observations, of Villa 2 and Villa 6, between 6/9/25 and 6/12/25, no activities were occurring. The Activities Director was also not observed to be spending 30 minutes in each villa at any time from 6/9/25 through 6/13/25.</p> <p>During an interview with Resident 20, on 6/12/25 at 1:00 p.m., she indicated she stayed in her bed most of the time, but would like to know what activities were occurring and when they were scheduled in case she wanted to go. No one ever came around to tell her.</p> <p>During a confidential interview, between 6/9/25 and 6/16/25, Staff 101 indicated the Activities Director was in the villa earlier and played balloon toss she thought with about five residents for about five minutes and then left.</p> <p>During a confidential interview and observation, between 6/9/25 and 6/16/25 from 8:00 a.m. to 2:00 p.m., Staff 102 indicated the Activity Director was in the villa earlier for a few minutes, a balloon toss was scheduled for this afternoon, but no balloon toss or any other activity had occurred. Two balloons were sitting on the dining room table with four residents and a family member. The family member indicated the Activity Director was going to be right back with ice cream for the residents. He also indicated the balloon toss did not occur.</p> <p>A review of the activity calendar which hung on the wall in a villa, on 6/12/25 at 2:00 p.m., indicated the Baking with Residents activity was canceled. The Activities Director she was going to be passing ice cream to the CNAs for National CNA Week and then to the residents.</p> <p>During the Resident Council meeting, on 6/10/25 at 1:01 p.m., Resident 8 indicated there were no outings, but she would like to have those. Resident 20 indicated the monthly calendar of activities provided to the residents was small and she couldn't read it. The activities were not held in every villa but were only held at specific [NAME]. There were not a lot of activities, at the [NAME], but they did have a musical in one villa a long time ago and she enjoyed that. The staff used to bring residents to activities at a villa at that time. The evenings had no activities. Bingo was listed on the calendar several times, but they didn't know where it was, if any. She would attend more activities, if she only knew where they were at.</p> <p>During a confidential interview, between 6/9/25 and 6/16/25, Staff 106 indicated activities were completed by CNAs and they didn't have time. If they tried to do activities then showers weren't done. Coloring was all the residents had for activities. The Activities Director completed the Resident Council meeting but was only at the meeting for 5 minutes. The Activity Director just documented from a small list of questions. The Activity Director wasn't provided with help to do the activities in all the [NAME]. Staff were supposed to conduct activities and were asked to take residents to activities in other [NAME] if a resident asked to go. Staff would take turns staying in the villa if a resident wanted to go to an activity.</p> <p>(continued on next page)</p>		

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<p>F 0679</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, 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.</p> <p>During random observations, between 6/9/25 and 6/16/25 from 10:00 a.m. to 10:20 a.m., of Villa 8 the following concerns were identified:</p> <ul style="list-style-type: none"> - Two residents were conducting therapy. The remaining residents were in their rooms in bed. No activities were occurring. - Two residents were sitting at the dining table, and one resident was sitting in a recliner in the hearth area. The TV was on, but no residents were observed watching it. No activity was occurring. <p>During random observations, between 6/9/25 and 6/16/25 from 10:00 a.m. to 10:20 a.m., of Villa 7 the following concerns were identified:</p> <ul style="list-style-type: none"> - Two female residents were sitting alone at the dining table and one resident was at the kitchen counter. A CNA was in a resident's room assisting a resident. The TV was on in the hearth without sound and no activities were occurring. <p>During an interview, on 6/11/25 at 9:18 a.m., the Executive Director (ED) indicated anyone in a villa could transfer a resident into another villa for an activity. She had transferred residents herself. She would make sure that a staff member was in the building before leaving with a resident.</p> <p>During an observation of the Monthly calendar, on 6/11/25 at 9:27 a.m., the activities were to begin daily at 10:00 a.m. with Daily Chronicles. No specific villa location was on the calendar.</p> <p>During an observation, on 6/11/25 at 11:06 a.m., the Activities Director entered Villa 7 and indicated to the CNA that a karaoke day in Villa 2 would be conducted at 2:00 p.m. She checked the coloring sheets and indicated, Oh good, they have only one of those sheets left.</p> <p>During an observation, between 6/9/25 and 6/13/25, the Activities Director entered the villa, and a staff member asked her why the activities were held in Villa 2 most of the time. The Activities Director indicated it was because more residents in [NAME] 3, 4, and 2 attended the activities and it was closer for them to go to Villa 2.</p> <p>The Activity Director's Job Description, dated 1/24/24, included, but was not limited to, . The Activity Director will be held accountable and responsible for the decision making and must assure that an ongoing program of activities is designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident . 4. Involves residents in planning facility activity programs . 20. Assists bed residents by visiting with them, writing letters, running errands, making appointments, etc., as necessary . 16. Supervises activities as necessary .</p> <p>3.1-33(a)</p> <p>3.1-33(c)</p> <p>(continued on next page)</p>		

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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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<p>F 0679</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 an ongoing activity program designed to meet the interest and support the physical, mental, and psychosocial well being of each resident. This deficient practice had the potential to affect 66 of 66 residents residing in the facility. ([NAME] 2, 3, 4, 5, 6, 7, and 8)</p> <p>Findings include:</p> <p>1. During a random observations, on 6/9/25 from 10:00 a.m. to 2:30 p.m., of [NAME] 3, 4, 7, and 8 there were four residents sitting in the dining area. No activities were taking place. The activity schedule indicated reading the news and chronicles at 10:00 a.m., trivia games at 1:00 p.m., and music class at 2:00 p.m. None of the activities took place.</p> <p>During random observations, between 6/10/25 and 6/13/25, Residents 29 and 47 were observed sitting in a recliner during the day except for mealtimes. The residents were not engaged in any activities</p> <p>During an observation, on 6/11/25 at 2:15 p.m., no activities were observed. There were no activity staff in the villa. The Certified Nursing Aide (CNA) provided resident care. At 2:00 p.m., the scheduled activity was karaoke. This activity did not take place, and no residents were taken to another villa for the activity.</p> <p>During random observations, on 6/12/25 from 1:15 p.m. to 1:45 p.m., [NAME] 3, 7, and 8 were observed for activities. The residents were scheduled at 1:00 p.m., for an activity called balloon volley. The were no activities observed throughout the day. The Activity Director was observed pushing a cart with boxes of ice cream. She indicated she was passing out ice cream to the CNAs in each villa related to CNA appreciation week.</p> <p>During an interview, on 6/11/25 at 11:20 a.m., Licensed Practical Nurse (LPN) 4 indicated the residents barely had any activities. The activities that the Activity Director brings around are puzzles and word searches. The residents on the dementia unit were unable to do the puzzles. She indicated the activities of puzzles and word searches for the dementia unit were not appropriate.</p> <p>During an interview, on 6/12/25 at 11:38 a.m., the family member of Resident 53 indicated she visited the resident daily. There were no activities observed while she was there. She tried to take the resident out of the facility for activities so she would have something to do.</p> <p>During an observation, on 6/10/25 at 1:00 p.m., Villa 4 did not have residents sitting in the dining room or the common areas and no activities were being conducted.</p> <p>During an interview, on 6/11/25 at 9:55 a.m., the CNA 11 indicated she was working alone in her position and QMA 12 was working on medication administration. CNA 11 indicated Villa 4 was hard to provide assistance with activities during the 12-hour shift, due to all the other duties she was required to do.</p> <p>During an observation, on 6/11/25 at 9:59 a.m., Villa 4 had one resident in the common area and no activities were being conducted.</p> <p>During an observation, on 6/11/25 at 10:57 a.m., Villa 5 did not have any residents sitting in the common area and no activities were being conducted.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation, on 6/12/25 at 9:05 a.m., the Activities Director brought papers that were for the residents to color and the daily news to read. No residents were in the common area at that time.</p> <p>During an observation, on 6/12/25 at 10:00 a.m., Villa 4 did not complete the scheduled activity of balloon toss. There was one pink balloon on the dining table with four residents sitting around the table. Two of those residents were finishing their breakfast.</p> <p>During an observation, on 6/12/25 at 10:10 a.m., Villa 5 did not complete the scheduled activity of balloon toss. There were two yellow balloons on the dining room table, but there were no residents in the dining room or the common area.</p> <p>During an interview, on 6/11/25 at 10:58 a.m., CNA 11 indicated she was the only staff working in Villa 5. She often worked alone in the villa. The tasks she had to do was cleaning, laundry, re-heating the meals on top of providing general resident care duties.</p>		

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<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>Based on record review, and interview, the facility failed to ensure communication between the wound clinic, and documentation of wound assessments for 1 of 7 residents reviewed for wounds. (Resident 33)</p> <p>Findings include:</p> <p>The record for Resident 33 was reviewed on 6/10/25 at 8:49 a.m. The resident's diagnoses included, but were not limited to, type II diabetes and abrasion to the right ankle.</p> <p>The physician's order, dated 4/22/25, indicated the resident was to have a betadine moistened dressing to the wound, and covered with gauze and Coban.</p> <p>The physician's order, dated 5/20/25, indicated staff were to apply a collagen sheet (endoform) to the resident's wound bed, covered with a superabsorbent silicone border dressing. Change the dressing every other day.</p> <p>The physician's order, dated 6/8/25, indicated staff were to cleanse the resident's wound to the right lower extremity with normal saline, apply a collagen dressing, cover with a non-adherent dressing, wrap with a gauze, and secure with Coban every 48 hours for the wound. Staff were to date the dressing after the treatment was completed.</p> <p>The physician's orders, dated 6/10/25, indicated staff were to cleanse the resident's wound with hypochlorous acid (Vashe or similar) then apply a hypochlorous acid soaked 4 x(by) 4 gauze to the wound bed for 5 to 10 minutes after a wound assessment was completed. Apply acticoat to the wound bed and secure with gauze and Coban. Staff were to leave the resident's dressing intact until the next wound center appointment.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 4/16/25, indicated the resident was moderately cognitively impaired.</p> <p>The facility wound care notes, dated 4/1/25, indicated the resident had an abrasion to the right ankle. The measurements indicated the width was 2.50 centimeters (cm), the length was 2.50 cm and the depth was 0.30 cm. The wound had 30% (percent) granulation, 60% slough with serous drainage. The treatment indicated staff were to cleanse the resident's wound with wound cleanser and pat dry, medical grade honey, and apply calcium alginate with a bordered gauze.</p> <p>The wound assessment report, indicated the Nurse Practitioner (NP) was providing the treatments for the resident's wound, from 4/1/25 to 5/16/25. At that time the wound was classified as an abrasion.</p> <p>The clinical record lacked documentation of any wound assessments after 4/17/25.</p> <p>The clinical record lacked documentation of the wound center treatment, measurements, and appearance of the wound, from 4/17/25 through current (6/13/25).</p> <p>(continued on next page)</p>		

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<p>F 0684</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 10:00 a.m., Licensed Practical Nurse (LPN) 5 indicated when staff changed the residents wound dressing, they would do the measurements if needed. Staff documented the dressing changes and measurements in the treatment administration record (TAR). The resident's family did not want the wound care nurse at the facility to see the resident for wound care. The resident went weekly to the hospital wound care center. She would monitor for any signs and symptoms of infection such as increased pain, edema, redness, increased drainage, fever, increase in size, and odor. The resident was not on a low air mattress or wore pressure reducing boots. The interventions included, but were not limited to, repositioning every two hours and floating her heels.</p> <p>During an interview, on 6/12/25 at 10:30 a.m., the Regional Director of Clinical Operations (RDCO) indicated the wound care notes from the hospital wound care center had not been scanned into the clinical record for the nurses to read.</p> <p>During an interview, on 6/12/25 at 1:00 p.m., The RDCO indicated the medical records staff quit about 2 to 3 months ago. No staff member was responsible for scanning the resident documents. At that time the documents were not scanned in.</p> <p>During an interview, on 6/12/25 at 1:20 p.m., LPN 5 indicated the resident's wound was probably a stage II at that time. Staff were unable to see the wound report from the wound center at the hospital. The wound documents were not in the resident's clinical record. The wound center did not call the facility and give a verbal report. She indicated the only way she knew anything about the wound was when the resident's family members came in and told them. The LPN indicated she felt like the nurses should know measurements, and what treatment the wound care center provided.</p> <p>The Skin-Weight-Assessment policy, dated 10/9/23 included, but was not limited to, . It is the intent of the facility to assess the nutritional status as well as the skin condition status of each resident and to timely address any issues or any potential for issues related to weight and/or skin. The SWAT Team will monitor residents who meet the criteria (listed later) on a weekly basis to ensure that measures are in place to avoid loss in at risk for weight loss residents; as well as to avoid skin breakdown in residents at risk for skin breakdown---based on their medical assessments and overall health status .Ensure that care planned interventions are in practice. Ensure that trained nurses are performing treatments using Infection Control techniques .The Medical Director will review treatment protocols being used by Wound Care Specialists to include Wound Clinics and contracted Wound Care Providers to ensure that National Pressure Injury Advisory Panel Guidelines are being followed in treatment protocols .</p> <p>3.1-37</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on record review and observation, the facility failed to ensure residents received respiratory care and maintenance for 4 of 4 residents reviewed for respiratory therapy. (Resident 3, Resident 38, Resident 54, and Resident 35)</p> <p>Findings included:</p> <p>1. The record for Resident 3 was reviewed on 6/10/25 at 1:00 p.m. The resident's diagnosis included, but was not limited to, chronic respiratory failure.</p> <p>The current physician's order, dated 6/13/24, indicated for staff to always maintain the residents' oxygen at 3 liters per nasal cannula.</p> <p>The care plan, dated 6/13/24 and revised on 2/18/25, indicated the resident had Oxygen Therapy related to Ineffective gas exchange. The interventions included, but were not limited to, change the residents position every 2 hours to facilitate lung secretion movement and drainage, give medications as ordered by the physician, monitor for signs of respiratory distress and report to the physician, monitor for side effects and effectiveness, and oxygen via nasal cannula at 3 liters continuously.</p> <p>The current physician's order, dated 2/11/24, indicated staff were to change the resident's humidifier bottle once weekly on Sunday night shift and as needed.</p> <p>The current physician's order, dated 2/11/24, indicated staff were to change the resident's oxygen cannula/tubing once weekly on Sunday during the night shift and as needed.</p> <p>The review of the June 2025, Electronic Administration Record/Electronic Treatment Administration Record (EMAR/ETAR) indicated that the humidifier bottle and oxygen cannula tubing was changed on 6/8/25.</p> <p>During an observation, on 6/9/25 at 10:00 a.m., the oxygen concentrator was in the resident room with a reusable water humidification canister and tubing was not dated.</p> <p>2. The clinical record for Resident 54 was reviewed on 6/9/25 at 1:31 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and respiratory failure with hypoxia.</p> <p>The physician's order, dated 3/21/24, indicated staff were to maintain the resident's oxygen at 2 liters per nasal cannula.</p> <p>During an observation, on 6/9/25 at 11:00 a.m., the resident's humidification bottle was empty of water and dated (Tuesday) 5/27/25. The oxygen tubing did not have a date. The plastic bag attached to the concentrator had a date of 5/27/25.</p> <p>3. The clinical record for Resident 35 was reviewed on 6/9/25 at 12:31 p.m. The resident's diagnoses included, but were not limited to chronic obstructive pulmonary disease, and anxiety disorder.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The physician's order, dated 3/27/2025, indicated the resident was to have Oxygen at 2 Liters via nasal cannula as needed for shortness of breath.</p> <p>The physician's order, dated 3/27/25, indicated staff were to change the resident's humidifier bottle once weekly on Sunday night shift and as needed.</p> <p>The physician's order, dated 3/27/25, indicated staff were to change the resident's oxygen cannula/tubing once weekly on Sunday during the night shift and as needed.</p> <p>During an observation, on 6/9/25 at 1:00 p.m., the humidification bottle was dated 5/27/25. The nasal cannula tubing did not have a date and the plastic bag attached to the concentrator had a date of 5/27/25. The last scheduled change of the oxygen supplies should have been dated 6/8/25.</p> <p>4. The clinical record for Resident 38 was reviewed on 06/11/25 at 11:53 a.m. The resident's diagnosis included but were not limited to, COPD (chronic obstructive pulmonary disease).</p> <p>The physician's order, dated 5/4/25, indicated for staff to maintain the resident's oxygen at 3 liters per nasal at night only every night shift for COPD.</p> <p>During an observation, on 6/9/25 at 9:00 a.m., the resident's humidification bottle for oxygen was dated 5/27/25. The nasal cannula tubing did not have a date, the plastic bag attached to the concentrator had a date of 5/27/25.</p> <p>The current physician's order, dated 12/12/23, indicated staff were to change the resident's oxygen tubing, and humidification bottle, clean oxygen filter, inspect easy foam wraps (replace if soiled or missing), every Sunday for (SOA) shortness of air, and as needed</p> <p>The facility did not present a copy of the Respiratory Therapy policy.</p> <p>3.1-47(a)(6)</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** 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"> - 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]. - 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]. - If there was down time, please go to other [NAME] and grab any stock that was needed. - All toilets must be cleaned on every day, this was just days shift's responsibility. - Make sure all food was dated and labeled. - 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]. -Get Report from night shift aides, Receive pager and key, Record temperatures for all refrigerators/freezers/pantry. -Prepare breakfast. Obtain the temperature of food and record. -Start morning get ups. Check and change round on all residents. -7:45 a.m., serve room trays, serve the dining table from 8:00 a.m. to 8:30 a.m. -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. <p>(continued on next page)</p>		

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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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<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"> -Start POC charting. -First scheduled shower and complete skin man assessment. -Start the resident's laundry. -Do the remainder of the resident's get ups. -Check and change round on the residents. -Pick up and prepare lunch. -Set the dining room table. -Bring all residents out for lunch. -Lunch-Obtain food temperatures and record. -12:00 p.m., serve room trays, serve the dining table from 12:15 p.m. to 12:45 p.m. -Collect all lunch dishes and clean the kitchen. -Obtain the dish sanitizer temperature. -3:00 p.m. pass ice water to all residents. -Lay the residents down for afternoon naps. -Check and change rounds on the residents. -Conduct the second scheduled showers-Complete the skin man assessment. -Start resident's laundry. -Take lunch break. -Daily cleaning-Mondays and Thursdays mop the bathrooms, Wednesdays and Saturdays vacuuming. Tuesdays and Fridays delivery truck. -Begin getting residents up for dinner. -Check and change rounds on the residents. -Set the dining room table for dinner. -Dinner-obtain food temperatures and record. -5:00 p.m., serve room trays, 5:15 p.m. to 5:45 p.m., serve the dining table. <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>-Wash the dinner dishes. Obtain the dish sanitizer temperatures.</p> <p>-Spot clean the remaining rooms.</p> <p>-Collect all trash from the resident's rooms and take it out.</p> <p>-Ensure all dirty cups and dishes are out of the rooms.</p> <p>-Turn in the sheet to the nurse to ensure all tasks were done.</p> <p>-Finish the remainder of the charting (charting must be completed before clocking out and leaving).</p> <p>-Write out the report sheet on the residents to give to the night shift.</p> <p>-Give the night shift aide report. Hand off the pager and key.</p> <p>Deep cleaning of the rooms included:</p> <p>-Dust the windows sills, blinds, and air conditioning units.</p> <p>-Wipe down the bed frame, dresser, nightstand, and TV.</p> <p>-Clean/straighten drawers and closet.</p> <p>-Straighten up the remainder of the room.</p> <p>-Vacuum the carpet.</p> <p>-Clean the mirror, bathroom counter, shower, and toilet.</p> <p>-Collect all trash from the room.</p> <p>-Gather the resident's laundry.</p> <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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation, on 6/11/25 at 10:10 a.m., Resident 3 was ringing her bell and asked the CNA 11 to get her out of bed. CNA 11 told the resident that she could not get her up at this time due to being busy putting the groceries away.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on record review and interview, the facility failed to schedule 8-hour consecutive RN coverage for 1 of 2 months reviewed. (June 2025). This deficiency had the potential to affect the 66 of 66 residents currently residing in the facility.</p> <p>Finding includes:</p> <p>Review of the May and June 2025 as worked nursing schedule on 6/13/25, the following days were missing an RN or had the RN only scheduled for 5 hours:</p> <ul style="list-style-type: none"> - On 6/5/25, only 6.5 hours of consecutive RN coverage was worked. - On 6/6/25, only 5 hours of consecutive RN coverage was worked. - On 6/7/25, only 5 hours of consecutive RN coverage was worked. - On 6/8/25, no RN coverage was worked - On 6/13/25, no RN coverage was worked. <p>During an interview with the Regional Director of Clinical Operations, on 6/13/25 at 12:30 p.m., she indicated she was aware there might be missing days of RN coverage. The Director of Nursing (DON) was a working DON who covered a Villa as necessary and was involved in all aspects of the facility.</p> <p>3.1-17(b)(3)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on record review and interview, the facility failed to ensure insulins were administered as prescribed for 2 of 19 residents reviewed for pharmacy services. (Residents 33 and 37)</p> <p>Findings included:</p> <p>1. The record for Resident 33 was reviewed on 6/12/25 at 10:30 a.m. The resident's diagnoses included, but were not limited to edema, diabetes, right ankle wound, and unspecified dementia.</p> <p>The physician's order, dated 10/14/24, indicated staff were to administer the resident's Humalog per a sliding scale. The sliding scale for before meals and at bedtime was as follows: if the resident's blood sugar (BS) level was 150 to 200 mg (milligrams per deciliters) mg/dL, the staff were to administer 2 U (units) ; 201 to 250 mg/dL, administer 4 U; 251 to 300 mg/dL, administer 6 U; 301 to 350 mg/dL, administer 8 U; 351 to 400 mg/dL, administer 10 U; for a blood sugar level grater than 400 mg/dL, administer 10 units and call the physician.</p> <p>During the review of the June Medication Administration Record (MAR), on 6/16/25 at 1:00 p.m., indicated the following insulin administration times were observed:</p> <p>- On 6/2/25, the resident's BS was 214 and the resident's insulin was to be administered at 11:30 a.m. The record indicated the insulin was administered at 3.00 p.m.</p> <p>- On 6/4/25, the resident's BS was 207 and the resident's insulin was to be administered at 8:00 p.m., The record indicated the insulin was given at 11:07 p.m.</p> <p>The physician's order, dated 10/14/24, indicated staff were to administer the resident's 5 units of Humalog 2 times daily, subcutaneously.</p> <p>The review of the June 2025 MAR indicated, on 6/6/25 at 1:00 p.m., the resident's 5 units for the 8:00 a.m. dose was not administered.</p> <p>The physician's orders, dated 5/9/25, indicated staff were to administer the resident's 30 units of Lantus in the morning, subcutaneously. Staff were to hold the administration if the resident's blood sugar was less than 100 mg/d.</p> <p>The review of the June 2025 MAR, indicated the resident's 30 units of Lantus was scheduled to be given at 9:00 a.m. on 6/2/25. The record indicated the resident's Lantus 30 units were not given until 2:59 p.m.</p> <p>During an interview, on 6/12/25 at 1:33 p.m., RN 13 indicated there was no reason why the resident's Lantus was not administered at the ordered time.</p> <p>2.a The clinical record for Resident 37 was reviewed on 6/10/25 at 10:30 a.m. The resident's diagnoses included, but were not limited, diabetes mellitus due to underlying condition with diabetic neuropathy, hypokalemia, long term (current) use of insulin, and peripheral vascular disease.</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 - Few</p>	<p>A physician's order, dated 7/22/24, indicated the staff were to administer the resident's Lantus Solution 100 UNIT/ML (Insulin Glargine) 10 units subcutaneously at bedtime.</p> <ul style="list-style-type: none"> - On 6/1/25, the resident's insulin was to be given at 8:00 p.m. The documentation indicated the resident's insulin was administered at 5:43 a.m. on 6/2/25. - On 6/7/25, the resident's insulin was to be given at 8:00 p.m. The documentation indicated the resident's insulin was administered at 2:18 a.m. on 6/8/25. - On 6/8/25, the resident's insulin was to be administered 8:00 p.m. The documentation indicated the resident's insulin was administered at 2:05 a.m. on 6/9/25. - On 6/13/25, the resident's insulin was to be administered at 8:00 p.m. The documentation indicated the resident's insulin was administered at 11:08 p.m. - On 6/14/25, the resident's insulin was to be administered at 8:00 p.m. The documentation indicated the resident's insulin was administered at 1:59 a.m. on 6/15/25. - On 6/15/25, the resident's insulin was to be administered at 8:00 p.m. the documentation indicated the resident's insulin was administered at 1:56 a.m. on 6/16/25. <p>2.b. A physician's order, dated 10/14/24, indicated staff were to administer Resident 37's Humalog 5 unit subcutaneously two times a day. Staff were to hold the Humalog if the resident's BS level was less than 100.</p> <p>The review of the June 2025 MAR indicated the resident's Humalog was not administered on the following dates when the BS level was greater than 100 on the following dates and times:</p> <ul style="list-style-type: none"> - On 6/13/25, the resident's a.m. dose was not administered for a blood sugar level of 131 mg/dL. - On 6/14/25, the resident's a.m., dose was not administered for a blood sugar level of 138 mg/dL. - On 6/15/25, the resident's a.m., dose was not administered for a blood sugar level of 135 mg/dL. - On 6/6/25, the resident's p.m., dose was not administered for a blood sugar level of 132 mg/dL. - On 6/7/25, the resident's p.m., dose was not administered for a blood sugar level of 124 mg/dL. - On 6/13/25, the resident's p.m., dose was not administered for a blood sugar level of 129 mg. <p>The Guidelines for Medication Administration, dated 1/25/2019 and last reviewed 3/29/24, included, but was not limited to, . 2) Medications are administered in accordance with written orders of the physician . 7) The licensed individual records the administration on the resident's MAR at the time the medication is given . 11) If a dose of regularly scheduled medication is withheld .</p> <p>3.1-25(b)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow appropriate infection control guidelines related to complete surveillance documentation to analyze a pattern of know infectious symptoms and patterns. This had the potential to affect 66 of 66 residents residing in the facility. ([NAME] 2, 3, 4, 5, 6, 7, and 8)</p> <p>Findings include:</p> <p>The Quality Assurance Performance Improvement Meeting summary, dated 6/3/25, indicated the infection control book was not able to be located and the facility will continue to update the book for 2025. The Immediate Corrective Actions indicated Identified issue work on last 90 days continue to update.</p> <p>The review of the January 2025 updated Infection Control/Antibiotic Stewardship documentation, the following infections were documented:</p> <ul style="list-style-type: none"> - 4 respiratory infections for residents. - 11 urinary tract infections (UTIs) for residents. - 4 skin infections for residents. <p>The updated documentation lacked the date of onset, symptoms, culture date with results, re-culture date, isolation, resolution date, or whether the infection met the criteria.</p> <p>The villa floorplans lacked documentation of monitoring for patterns of infections.</p> <p>The review of the February 2025 updated Infection Control/Antibiotic Stewardship documentation, the following infections were documented:</p> <ul style="list-style-type: none"> - 7 respiratory infections for residents. - 9 urinary tract infections (UTIs) for residents. - 2 skin infections for residents. <p>The updated documentation lacked the date of onset, symptoms, culture date with results, re-culture date, isolation, resolution date, or whether the infection met criteria.</p> <p>The villa floor plans lacked documentation of monitoring for patterns of infections.</p> <p>The review of the March 2025 updated Infection Control/Antibiotic Stewardship documentation, the following infections were documented:</p> <ul style="list-style-type: none"> -12 urinary tract infections (UTIs) for residents. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 5 skin infections for residents.</p> <p>- 1 blood/other for residents.</p> <p>The updated documentation lacked the date of onset, symptoms, culture date with results, re-culture date, isolation, resolution date, or whether the infection met criteria.</p> <p>The villa floorplans lacked documentation of monitoring for patterns of infections.</p> <p>The review of the April 2025 updated Infection Control/Antibiotic Stewardship documentation, the following infections were documented:</p> <p>- 9 respiratory infections for residents.</p> <p>- 8 urinary tract infections (UTIs) for residents.</p> <p>- 2 skin infections for residents.</p> <p>The updated documentation lacked the date of onset, symptoms, culture date with results, re-culture date, isolation, resolution date, or whether the infection met criteria.</p> <p>The review of the May 2025 updated Infection Control/Antibiotic Stewardship documentation, the following infections were documented:</p> <p>- 6 respiratory infections for residents.</p> <p>- 13 urinary tract infections (UTIs) for residents.</p> <p>- 2 skin infections for residents.</p> <p>- 3 blood infections for residents.</p> <p>The updated documentation lacked the date of onset, symptoms, culture date with results, re-culture date, isolation, resolution date, or whether the infection met criteria.</p> <p>The review of the June 1 through 14, 2025 updated Infection Control/Antibiotic Stewardship documentation, the following infections were documented:</p> <p>- 2 skin infections for a resident.</p> <p>- 2 blood infections for a resident.</p> <p>The updated documentation lacked the date of onset, symptoms, culture date with results, re-culture date, isolation, resolution date, or whether the infection met criteria.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview, on 6/11/25 at 10:32 a.m., the Director of Nursing (DON) and Infection Preventionist (IP), indicated the Infection Prevention for identifying, tracking, monitoring and reporting diseases would be in the binder and should stay up to date. It had not been kept up to date and they couldn't find the Infection Prevention binder. They reproduced it from January to June 2025. All monitoring was now caught up. They had gone backwards for trending and tracking. It was important to keep the Infection Prevention up to date for education for staff and residents and for resident monitoring needs for the prevention of disease spread. Infections came from other people, so the Infection Prevention documentation was important for monitoring.</p> <p>During an interview, on 6/13/25 at 12:41 p.m., the Regional Director of Clinical Operations (RDCO) indicated the Infection Prevention binder could not be located. They started a new 2025 binder, going back 90 days immediately on 6/3/25. They started to work to update the Infection Prevention binder back from January 2025 to now. A new IP had been recently hired and still had to be IP certified. Currently the Assistant Director of Nursing (ADON) was certified and monitored with the Infection Prevention. If she were to quit, the DON would take over the IP position to continue monitoring. The DON was also IP certified.</p> <p>The Guidelines For Infection Prevention and Control policy, dated 8/17/23, included, but was not limited to, . Surveillance: A surveillance system designed to do the following will be maintained. Identify possible communicable diseases or infections before they can spread to other persons in the facility. Ensure that any communicable diseases are identified and reported timely and to the required parties/agencies. Ensure that standard and transmission-based precautions are followed in an effort to prevent the spread of infection. Define when and how isolation should be used for a resident including, but not limited to: The type and duration of the isolation, depending on the infectious agent or organism involved; and Making certain that the isolation used is the least restrictive possible for the resident under the current circumstances and findings. Being sure that no employee of the facility who exhibits a communicable disease or who had an infected skin lesion is allowed to have direct contact with any resident or with any resident's food--if direct contact could transmit the disease .</p> <p>3.1-18(b)(1)(A)</p> <p>3.1-18(b)(3)</p>		