STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. Building B. Wing	10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Covington, The	1600 E Liberty St Covington, IN 47932

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from neglect when staff ignored a resident's continued reports of acute pain and his request to be sent to the hospital which resulted in prolonged pain and a delay of treatment for 1 of 3 residents reviewed for neglect (Resident B). The immediate jeopardy began on 9/24/25 at 10:00 p.m., when Certified Nursing Aide (CNA) 3 observed Resident B to be sweaty and he complained of acute pain. CNA 3 reported his concerns to Licensed Practical Nurse (LPN) 4. CNA 3 and CNA 8 reported to LPN 4 around 1 or 2 a.m., that Resident B was still in pain and wanted to see the nurse. LPN 4 failed to assess the resident or report the resident's change of condition to a physician. CNA 3 reported Resident B's pain to the incoming dayshift nurse, Registered Nurse (RN) 5. On 9/25/25 around 7:40 a.m., CNA 6 heard Resident B screaming out and informed RN 5. Housekeeper (HK) 10 and two CNAs reported Resident B's pain and discomfort to RN 5. RN 5 refused requests to go see Resident B. Resident B told CNA 6 he wanted to go to the hospital, and CNA 6 reported the request to RN 5. On 9/25/25 Resident B's family member was on the phone with him for over 45 minutes before they called the facility directly and told management they wanted Resident B sent to the hospital immediately. Resident B was finally sent to the hospital on 9/25/25 at 9:45 a.m., where he required operative intervention under anesthesia for a bowel obstruction, and was diagnosed with gallbladder cancer. The Administrator, Director of Nursing (DON), and Regional Clinical Support (RCS) were notified of the immediate jeopardy on 10/16/25 at 3:15 p.m. The immediate jeopardy was removed on 10/17/25, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During a confidential interview on 9/15/25 at 10:00 a.m., it was indicated, Resident B called a family member and was on the phone for more than 45 minutes complaining of pain without getting help from a nurse. The family member finally hung up with the resident and called the facility directly. The family member spoke to the Business Office Manager (BOM) and indicated Resident B needed to go to the hospital immediately. The BOM interrupted morning meeting to notify the DON and Assistant Director of Nursing (ADON) that the family was demanding the resident be sent to the hospital. The family member was very upset over Resident B's treatment and indicated he was not taken seriously and was neglected by both the night shift and morning shift nurses. During an interview on 10/15/25 at 1:40 p.m., with the DON present, CNA 6 indicated on 9/25/25 she heard Resident B screaming for help around 7:00 a.m. She went to see what was wrong. Resident B told her he was in pain and wanted the nurse. CNA 6 assured him she would let the nurse know. CNA 6 immediately went to RN 5 who indicated, he's going to have to wait. CNA 6 went to help with breakfast in the dining room. A little while later, HK 10 came to ask CNA 6 if the nurse ever went to check on Resident B because he was still screaming out for help. CNA 6 went to RN 5 a second time to ask if she had been to see Resident B, to which RN 5 indicated, oh my F------ God. CNA 6 told RN 5 that Resident B may need some pain medication and Qualified Medication Aide (QMA) 11, was standing there too. CNA 6 indicated CNA 7 came to her and told her that she had also told RN 5 that Resident B was in pain and RN 5 did not care. Later that morning, CNA 6 and CNA 7 checked on Resident B together, while RN 5 and QMA 11 stood in the hallway, and found that he was on the phone with his family member who was really upset. The resident's family wanted the resident to be sent to the hospital. CNA 6 indicated she told RN 5 that Resident B's family member was upset and wanted him to go to the hospital, but RN 5 said no. CNA 6 indicated most everyone in the building knew about Resident B being in pain because of how loudly and repeatedly he was yelling for help. After RN 5 told CNA 6 she would not send Resident B out, CNA 6 and 7 went to the ADON and told him their concerns. CNA 6 indicated it was neglectful in her opinion, but she was just the CNA, so she couldn't do anything but keep telling the nurse. The DON indicated the Business Office Manager (BOM) got involved after Resident B's family member called the facility and talked to the BOM. When the DON arrived at the facility the BOM stuck her head in at morning meeting and said, Resident B's family wanted Resident B sent out to the hospital now. The DON indicated she did not receive any calls the previous night, so this was the first time she had heard about it. The DON told RN 5 to start the process of sending Resident B to the hospital. RN 5 said, I have pills to pass. The DON indicated she told RN 5 no, he needs to be sent out now. CNA 6 indicated RN 5 made a comment after Resident B was sent to the hospital, saying I hope they keep him. During an interview on 10/16/25 at 11:09 a.m. RN 5 indicated she came in and got report from LPN 4

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident with constipation, no recent bowel movements (BM), and reporting pain was monitored and treated timely resulting in the resident having a delay in treatment and requiring interventions under anesthesia for a severe fecal impaction for 1 of 5 residents reviewed for quality of care related to their bowel management program (Resident B), and the facility failed to ensure an effective protocol was put in place for the ongoing monitoring of 5 of 5 residents reviewed for quality of care related to the bowel management program (Residents B, E, F, G, and H). The Immediate Jeopardy (IJ) began on 9/24/25 when Resident B began to experience and complain of acute pain. His last recorded BM was 9/19/25 at 11:17 a.m. A Kidney, Ureter and Bladder (KUB) scan (a diagnostic scan of the abdominal area) was completed 9/23/25 and confirmed constipation. No orders or treatment were obtained after the results of the KUB. On 9/23/25 two doses of PRN medications were given for constipation and documented as ineffective. No additional treatment or notification of the physician were documented. During night shift on 9/24/25, Resident B began to experience acute pain and reported his pain to two night shift Certified Nursing Aides (CNAs). The CNAs reported the resident's pain to Licensed Practical Nurse (LPN) 4. No additional treatment or notification of the physician about the resident's change of condition was documented. Resident B's pain continued and on 9/25/25 CNAs 6 and 7 reported Resident B's pain to RN 5 multiple times and reported Resident B's request to go to the hospital. RN 5 did not assess the resident, call the physician, or send the resident to the hospital. On 9/25/25 Resident B's family member got in contact with the Business Office Manager (BOM) demanded that the resident be sent to the hospital. Resident B was sent out emergently on 9/25/25 at 9:45 a.m. At the hospital, Resident B required operative intervention under anesthesia for a bowel obstruction and was diagnosed with gallbladder cancer. The Administrator, Director of Nursing (DON), and Regional Clinical Support (RCS) were notified of the immediate jeopardy on 10/16/25 at 3:15 p.m. The immediate jeopardy was removed on 10/17/25, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: On 10/15/25 at 10:30 a.m. Resident Bs medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to a history of constipation. Resident B's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated his Brief Interview for Mental Status (BIMS) score was 15 out of 15 indicating he was cognitively intact. He was totally dependent on staff to roll him from side to side while he was laying in bed and transfer him to and from the toilet. He was always incontinent. A Nurse Practitioner (NP) progress note, dated 9/3/25, indicated Resident B was at risk for opioid versus immobility induced constipation. Resident B had a comprehensive care plan, initiated on 9/9/24, which indicated he was at risk for bowel irregularity related to his diagnoses, decreased bowel mobility, and medications with a target goal to have a BM every 2 to 3 days. Interventions for this plan of care included, but were not limited to, record BMs, assess resident, and if no BMs notify the MD. Prior to being sent to the hospital on 9/25/25, the last recorded BM was recorded on 9/19/25 at 11:17 a.m. The record lacked documentation of a bowel movement between 9/19/25 and 9/25/25. A progress note, dated 9/23/25 at 1:45 p.m., indicated Resident B complained of abdominal discomfort. He had active bowel sounds and a firm, but non-tender abdomen. On 9/23/25 a Kidney, Ureter, Bladder scan (KUB) was ordered to evaluate the gastrointestinal systems. The results were received on 9/23/25 at 2:14 p.m., and the results confirmed constipation. The record lacked documentation the physician was notified of the KUB results or of any new orders or interventions to address the KUB results. Resident B's September 2025 MAR indicated he received Naloxegol Oxalate (treats opioid induced constipation) 25 mg every morning for constipation. He received Amitiza (treats certain types of chronic constipation) 24 microgram (mcg) two times a day for constipation. Resident B's September MAR indicated he received Tramadol (opioid pain medication) 50 mg three times a day for pain. The September 2025 Medication Administration Record (MAR) indicated Resident B received one as needed (PRN) docusate (stool softener) on 9/23/25 at 2:07 p.m. which was recorded as ineffective. On 9/23/25 at 5:31 p.m., Resident B received a PRN dose of Miralax (laxative), which was recorded as ineffective. The record lacked documentation of a physical assessment of the Resident B on 9/23/25, 9/24/25, and 9/25/25. The record lacked documentation of physician notification of the resident's continued constipation and ineffective PRN medications. Resident B had an active order for Tylenol PRN every 4 hours for mild pain of 1-3 on a scale of 1-10. One dose of