| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155233 | A. Building<br>B. Wing | 01/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Waters of Batesville, The | 958 E Hwy 46<br>Batesville, IN 47006 |

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

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on interview and record review, the facility failed to prevent staff to resident verbal abuse for 2 of 3 residents reviewed for abuse. (Residents D and F)Findings include:1.During an interview, on 01/29/2026 at 9:22 A.M., Resident D indicated Certified Nurse Aide (CNA) 6 was mean and said bad words to him. He would not specify what the bad words were exactly.The clinical record for Resident D was reviewed on 01/30/2026 at 1:25 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 10/23/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, cerebral palsy (neurological disorders appearing in infancy that permanently affect body movement), diabetes, and renal insufficiency. The resident was frequently incontinent of urine and bowel.In a CONFIDENTIAL WITNESS STATEMENT, dated 01/11/2026, Resident D indicated CNA 6 had said a bad word to him. Resident D had informed CNA 6 he needed to use the bathroom. The resident reported the aide responded, I will come back later; I've got other people to worry about. The resident stated he rang the call light again because by now he had a bowel movement accident while waiting. The resident reported the aide told him, You need to keep your mouth shut and you don't need to get into other people's business. The resident stated while the aide was gathering supplies for his personal care due to his bowel accident, the resident overheard the aide in the hallway say, I am sick and tired of taking care of (Resident D). The resident reported he did not feel well at the time and believed his stomach discomfort was related to the food that had been served that day. The resident also described a separate incident on an unknown date involving the same CNA. The resident reported the aide told him, If you don't do what I want you to do-meaning utilize the call light for assistance, you will need to find another nurse to help.2. During an interview, on 01/29/2026 10:15 AM., Resident F indicated CNA 6 was hostile towards him. The CNA went out of his way to act like he was hurting himself trying to help the resident; and that made the resident feel uncomfortable. The CNA was overly dramatic and made (negative) sound effects when he was helping him. The clinical record for Resident F was reviewed on 01/30/2026 at 1:40 P.M. A Quarterly MDS assessment, dated 10/15/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure and diabetes. The resident was occasionally incontinent of urine and frequently incontinent of bowel. A CONFIDENTIAL WITNESS STATEMENT, dated 01/11/2026, indicated Resident F stated CNA 6, over the past several days, had appeared irritable and a little clumsy. The Resident described the aide's overall demeanor as off stating the aide seems more irritable with everything in general and had been all around grumpy. The resident felt the aide's attitude upon entering his room suggested he may have been upset and was, taking it out on him.A staff member's statement, from the facility's investigation into the incident on 01/11/2026, was provided by the Administrator on 01/30/2026 at 1:12 P.M. The statement, from Qualified Medication Aide (QMA) 3, indicated while administering medication to Resident D, he was visibly upset and said CNA 6 had told him to shut his damn mouth and to not talk when he was talking. The resident tried to explain to<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | CNA 6 what he wanted regarding a personal care item, and CNA 6 replied with, I told you to shut your Damn mouth, and then the CNA left the room. When the QMA went into Resident F's room, the resident indicated CNA 6 seemed to be having a bad day and wasn't in a pleasant mood, which made the resident feel uncomfortable. The resident stated he had never felt like that before and hoped that CNA 6 would cheer up soon. During an interview, on 01/30/2026 at 10:43 A.M., CNA 4 indicated, on 01/11/2026, she had a couple residents say to her CNA 6 had been more stressed out and would get irritated with the residents not being fast enough, like when they were rolling side to side during care. A resident had reported to her that CNA 6 had been rude to her verbally and had been impatient with her while giving her care. This was reported to her before 01/11/2026.During an interview, on 01/30/2026 at 10:08 A.M., CNA 2 indicated in the past, CNA 6 had been snappy with residents, and she had reported it to the Administrator. That instance was around the end of November or the beginning of December.The current undated DIGNITY policy was provided by the Administrator on 01/30/2026 at 10:12 A.M. The policy indicated, .Staff will not speak in a manner that could be interpreted as even minimally condescending/critical or argumentative nor in a volume any louder than is absolutely necessary as this can be interpreted as meeting criteria for abuse.Staff will not use any profanity or vulgar words in the presence of the resident and under no circumstances directed at a resident. This would meet abuse criteria.The current ABUSE PREVENTION PROGRAM policy, dated 10/22/2022, was provided by the Administrator on 01/30/2026 at 10:12 A.M. The policy indicated, .Verbal Abuse.Any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their family, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability.3.1-27(b) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to update a care plan related to suicidal ideation for 1 of 5 residents reviewed for care plans. (Resident B)Findings include:The clinical record for Resident B was reviewed on 01/29/2026 at 9:51 A.M. An admission minimum data set (MDS) assessment, dated 12/30/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, traumatic brain dysfunction (neurological and physical impairments of physical, cognitive, and emotional brain function) , anoxic brain damage (the brain was completely deprived of oxygen, causing widespread brain cell death within minutes), anxiety, and depression. The resident had little interest or pleasure in doing things nearly every day, the resident was feeling down/depressed/hopeless half or more of the days, the resident was feeling tired or having little energy nearly every day, and the resident was feeling bad about self.The resident was admitted to the facility on [DATE].A Progress Note, dated 12/28/2025 at 3:37 P.M., indicated there was a change in the resident's condition. The resident was a danger to self or others for suicide potential. The resident has asked for Adderall (a central nervous system stimulant). The resident was informed that the medication was not due at that time. The resident started crying and stated, I'm going to kill myself. The resident was placed on 15-minute checks and the physician was notified.The care planned lacked a care plan for suicidal ideation until 01/16/2026.During an interview, on 01/30/2026 at 9:44 A.M., Licensed Practical Nurse (LPN) 9 indicated on the afternoon of 12/28/2025 she was completing her medication pass and the resident had asked for more Adderall. She had told her she was unable to give her more at that time. She started to work with the resident's gastric tube, and she looked at the resident, and her face was blood red and she was crying. She had taken her finger and pointed to her neck and she was mouthing something; she wasn't quite able to understand the resident. She was finally able to read her lips and [NAME] her if she was saying she wanted to kill herself, and the resident said Yes.During an interview, on 01/30/2026 at 10:14 A.M., the Social Service Director indicated the resident came from home. There was a communication barrier with the resident. She couldn't speak clearly. She didn't always talk to staff related to incidents with residents, she was not sure if nursing staff talked to them or not. Residents were care planned for suicidal ideation. If the nurse had asked the resident if they wanted to kill themselves and the resident said yes, then she would consider that suicidal ideation.The current facility policy titled, Baseline Care Plan Assessment/Comprehensive Care Plans update 09/18/2018, was provided by the Administrator on 01/30/2026 at 11:25 A.M.It is the policy of the facility to ensure that every resident has a Baseline Care Plan completed and implemented.The Comprehensive Care Plan will further expand on the resident's medical, nursing, physical functioning, mental and psychosocial needs.3.1-31(a) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and observation, the facility failed to ensure residents received adequate supervision to prevent them from exiting the building and provide One to One supervision for 2 of 3 residents reviewed for accidents. (Residents C and B) Findings include:1.The clinical record of Resident C was reviewed on 01/29/2026 at 10:54 A.M. The resident's diagnosis included, but was not limited to, non-Alzheimer's dementia (a decline in mental abilities) and arthritis.<br><br>A physician's order dated 11/11/2025 at 6:00 A.M, indicated Resident C had a wander guard on his ankle for risk of elopement from the facility that needed checked for placement and function daily.<br><br>A Social Services Progress Note, dated 01/16/2026 at 5:31 P.M., indicated Resident C had attempted to follow a visitor out of the facility. The resident's wander guard activated alerting staff. The resident did not exit the facility and was redirected away from the door. 15-minute monitoring of the resident was initiated for 48 hours.<br><br>The local weather information for the temperature on 01/17/26, was reviewed on 02/06/2026 at 9:00 A.M., at Accuweather.com and the air temperature was between 23 and 34 degrees Fahrenheit.<br><br>The cdc.gov website, indicated cautioned for elderly persons without food, clothing or heating, are at higher risk for frostbite or hypothermia.<br><br>During an interview, on 01/29/2026 at 8:45 A.M., Resident C indicated he had told staff he did not want to be at the facility anymore, and they had told him he could not go outside. He then went to a facility door and used a code to exit the facility, and nobody found him outside. He came back to the facility once he got cold and waved at staff through a side door with a window.<br><br>During an interview, on 01/30/2026 at 10:40 A.M., Licensed Practical Nurse (LPN) 2 indicated she was working the night of 01/17/2026. Around 8:30 P.M. that night she responded to the front door of the facility for a wander guard alarming at the door. After turning off the alarm, she witnessed Resident C in his powered scooter heading down the hallway away from her. Then around 9:00 P.M. she witnessed Resident C sitting in front of the nurse's station with other residents. At 9:45 P.M. staff could not find Resident C, so they began protocol for a missing resident. While searching they discovered him standing outside the doors at the end of 39 hallway. He was standing outside the door waving his cowboy hat at staff. He was wearing his cowboy hat and a pair of black underwear with no shirt on. He was scared, cold, and shivering.<br><br>During an interview, on 01/29/2026 at 12:03 P.M., RN 3 indicated she had seen Resident C with other residents in the atrium at 9:15 P.M. and then went into another resident's room. At approximately 9:45 P.M. Resident C was found standing outside the doors of the facility at the end of 39 hallway. He was cold and had some small scratches on his arm and a small scratch above his left ear. He was sent to the emergency room, and a few hours later returned with no findings of additional injuries. He did have his wander guard on, and it was functioning.<br><br>During an interview, on 01/29/2026 at 12:37 P.M., the Maintenance Director indicated that every door but three had an alarm attached to it that if it was opened even with the code, it would sound an alarm that could only be turned off with a key. Of those three doors two of them had a wander guard<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | alarm on them. The wander guard alarm would sound if any residents with a wander guard got to close to the exit door. The only door in the facility a resident could get out of with a wander guard in place, without an alarm sounding was the doors at the back of the Main Dining Room. Those doors only required a punch code to exit, and there was no additional alarm system if the code was entered correctly.<br><br>During an interview, on 01/30/2026 at 10:22 A.M., the Administrator indicated that the cameras at the facility were not working, and they were not able to determine what door Resident C exited the facility through on 01/17/2026. The resident was able to repeat the code to the door and all of the door codes in the facility have been changed.<br><br>During an interview, on 01/30/2026 9:56 A.M., the Social Services Director indicated that Resident C did get confused and would exit seek. The day before the incident he was placed onto 15-minute checks, because he had attempted to exit the facility behind visitors. The only current new intervention for Resident C was conducting one on one monitoring with the resident.<br><br>A current care plan, with the start date of 12/12/2025 and revised date of 12/15/2025, indicated Resident C was at risk for elopement as evidenced by a history of wandering and a diagnosis of Dementia. The interventions included but were not limited to: dated 12/12/2025 monitor doors when staff and visitors come and go. If wandering in potential unsafe area or situation, redirect to a safe area, and reassess regularly.<br><br>On 01/30/2026 at 10:12 A.M., the Administrator provided a current copy of the document titled Elopement and Missing Resident Prevention with a revision date 04/20/2023. It included, but was not limited to, It is the policy of this facility that all residents are provided adequate supervision to meet each resident's nursing and personal care needs.<br><br>2. The clinical record for Resident B was reviewed on 01/29/2026 at 9:51 A.M. An admission MDS assessment, dated 12/30/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, traumatic brain dysfunction (neurological and physical impairments of physical, cognitive, and/or emotional brain function), anxiety, and depression.<br><br>The resident was sent to the hospital on [DATE] for attempted suicide. The resident was admitted back to the facility on [DATE] and was placed on 1:1 observation where they remained to date.<br><br>During an observation, on 01/29/2026 at 8:45 A.M., Resident B was lying in her bed. There was a staff member sitting in the hallway outside of her room.<br><br>During an observation, on 01/29/2026 at 10:00 A.M., Resident B was lying in her bed with her eyes closed. There was no call light within reach. There was a staff member sitting in the hallway outside of the resident's rooms. Across the hall was Resident C's room. Resident C was walking around in his room.<br><br>During an observation, on 01/29/2026 at 10:29 A.M., Resident B and Resident C were both in their rooms. There was a staff member sitting in the hallway between the residents' rooms. There were no staff present in the main hallway leading to the main entrance. The Residents' rooms were directly across from each other. There were approximately 9 steps from the residents' rooms to the end of the hallway that led to the main entrance and there were approximately 19 steps from the end of the hallway to two exit doors that had push keypads and alarms. If one of the residents walked 9 steps down the<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | hall to the main hallway, they would be out of the staff member's sight.<br><br>During an observation, on 01/30/2026 at 9:56 A.M., there was a staff member sitting in the hallway outside Resident B and C rooms. The staff member was looking at her phone. There were no staff present in the hallway leading to the main entrance.<br><br>During an observation, on 01/30/2026 at 1:04 P.M., Resident C was nowhere to be seen in his room. The ADON indicated the resident was in the bathroom with the door closed. The ADON was sitting in a chair in the hallway. Resident B was in her room in her wheelchair with other staff in the room.<br><br>During an interview, on 01/29/2026 at 11:26 A.M., CNA 5 indicated if a resident was on one to one (1:1) observations they document it on paper.<br><br>During an interview, on 01/29/2026 at 11:40 A.M., QMA 7 indicated if a resident was on 1:1 observation then she would be informed by the Administrator or the nurse.<br><br>During an interview, on 01/29/2026 at 2:17 P.M., Resident B's primary care physician indicated if a resident required 1:1 observation then that would mean one staff to one resident.<br><br>During an interview, on 01/29/2026 at 2:30 P.M., CNA 5 indicated they were providing 1:1 observation for Resident B and Resident C at that time. She was sitting in a chair in the hallway, outside the resident's rooms. If she was unable to redirect Resident C, then she would call for staff assistance. The staff had a messenger app they could call for staff or call the ADON. Resident C never usually went anywhere.<br><br>During an interview, on 01/29/2026 at 2:34 P.M., the ADON indicated 1:1 observation was having eyes on the resident at all times. The residents could not be left alone at any time. They had one staff member that was assigned to the two residents on 1:1 observation. The staff could always call or text additional staff if they needed help. Resident C was mobile with a walker.<br><br>During an interview, on 01/29/2026 at 2:51 P.M., the Administrator and the Cooperate Clinical Nurse indicated for 1:1 observation there was a staff member posted where they can visibly see the resident at all times. There were always staff there to intervene if needed. Resident C was easily redirected.<br><br>During an interview, on 1/30/2026 at 10:14 A.M., the Social Service Director indicated Resident B was placed on 1:1 observation when she returned from the hospital recently and Resident C was on 1:1 observations also for being outside the building. 1:1 observations meant eyes on the resident at all times. She wasn't sure what the facility policy was for 1:1 or if it was one staff to one resident. There were management staff numbers that staff could call for help if needed. They also had a communication line for staff. Resident C was easily redirected. She was not sure what other staff would do if Resident C wasn't able to be redirected and walked up the main hallway. If it were her then she would leave Resident B and follow Resident C up the hallway.<br><br>During an interview, on 01/30/2026 at 10:25 A.M., RN 10 indicated at that time she was the person in charge for 1:1 with Resident B and Resident C. If Resident C was not redirectable and there were no staff available, then she would have to just let him (Resident C) walk away because she couldn't leave Resident B. At the time of the interview there were no staff in the main hallway leading to the main entrance.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The current facility policy titled, Guidelines for One-on-One Supervision dated 05/17/2023, was provided by the Administrator on 01/30/2026 at 8:55 A.M. The policy indicated, .The guidelines emphasize a proactive intervention promoting enhanced physical and psychosocial well-being. The facility recognizes that there may be occasions in which standard approaches are not successful such as redirection and counseling. One to One supervision provides additional supervision and guidance to the resident at times when the resident may have decompensated mentally and/or physically.A staff member will be assigned to remain in direct supervision of the resident during the time that the one to one supervision is utilized.One to One supervision at a minimum involves that the resident remain in direct visual surveillance at all time.<br><br>This citation relates to Intake 2721930.<br><br>3.5-45(a)(1)<br><br>3.1-45(a)(2) |