STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155274	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Rockport Skilled Nursing Facility, The	815 W Washington St Rockport, IN 47635

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review, the facility failed to ensure residents were free from misappropriation for 1 of 1 residents reviewed for misappropriation. Three checks were taken from a resident's checkbook by a QMA. The QMA then used two checks in an attempt to transfer money from the resident's bank account to the QMA's account. (Resident D)Finding includes:During a review of facility reported incidents on 3/9/26 at 11:15 A.M., an incident dated 12/2/25, indicated Resident D notified staff that he received a phone call from his bank regarding suspicious activity on his account. QMA 13 was terminated from employment and arrested. Resident D's account was recovered, and proper paperwork was completed to restore funds. A review of the facility's investigation into the incident on 3/9/26 at 1:30 P.M., indicated Resident D's bank notified the resident of suspicious activity on his account on 12/1/25 at 3:30 P.M. On 12/2/25 at 2:00 P.M., Resident D notified staff. Facility staff, along with the resident, contacted the bank and were informed QMA 13 had attempted to cash a check (#1700) from the resident for $1,200.00. A review of the resident's check book showed that other check numbers 1695, 1698, and 1699 were missing and unaccounted for. It was determined that check number 1698 had been cashed for $700.00 on 11/30/25. Police were notified.During an interview on 3/10/26 at 11:25 A.M., the Facility Administrator indicated QMA 13 had stolen multiple checks from Resident D's checkbook and successfully cashed a check for $700.00. QMA 13 attempted to cash a second check for a larger amount and when asked for identification, QMA 13 fled the bank, leaving behind her driver's license. A bank employee then contacted the resident, and the facility was notified and confirmed QMA 13's information matched the driver's license. Police were notified and QMA 13 was arrested and terminated from employment after arriving for her next scheduled shift. On 3/10/26 at 12:18 P.M., the Facility Administrator supplied a facility policy titled, Abuse Prevention Program, dated 10/22/22. The policy included, It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property . Exploitation/Misappropriation of resident property: is the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the cognitively intact resident's consent .This citation relates to intake 2683467.410 IAC (Indiana Administrative Code) 16.2-3.1-28(a)

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

Printed: 06/05/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review, the facility failed to ensure a baseline care plan was developed for a newly admitted resident within 48 hours of admission for 1 of 2 newly admitted residents with pressure ulcers. A resident admitted on a Thursday and had no baseline care plan in place until the following Monday. (Resident C)Finding includes:During record review on 3/9/26 at 1:45 P.M., Resident C's diagnoses included but were not limited to, aphasia following other nontraumatic intracranial hemorrhage.Resident C's admission date was 3/5/26. Resident C's physician orders included but were not limited to, coccyx and right buttock: cleanse with wound cleanser, pat dry, apply calcium alginate with Medihoney, and cover with border foam dressing (started 3/5/26). Resident C's record contained no care plan or baseline care plan. During a review on 3/10/26 at 9:30 A.M., Resident C's record contained a baseline care plan for admission, dated 3/9/26 at 4:36 P.M.During an interview on 3/10/26 at 11:30 A.M., the Assistant Director of Nursing (ADON) indicated a resident baseline care plan should be put into place within one to two days after admission. On 3/10/26 at 12:18 P.M., the Facility Administrator supplied a facility policy titled, Baseline Care Plan Assessment/Comprehensive Care Plans, dated 3/23/21. The policy included, It is the policy of the facility to ensure that every resident has a Baseline Care Plan completed and implemented within 48 hours of admission . 1. Upon admission to the facility, the admitting nurse will initiate the Baseline Care Plan Assessment to establish an initial plan of care to identify potential problems and to initiate appropriate goals and interventions. The Baseline Care Plan Assessment will be completed within 48 hours of admission and will address areas of imminent concern. At a minimum, it will address initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and PASARR recommendations. Observations, interview(s) with the resident and/or their representative, information obtained from the physician as well as review of the available medical records on admission will be reference points for development of the Baseline Care Plan Assessment. a) The IDT Team will assist in the completion and implementation of the Baseline Care Plan to ensure compliance of completion within 48 hours per the regulation .This citation relates to intake 2785193. 410 IAC (Indiana Administrative Code) 16.2-3.1-30(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services were provided for treatment of an existing pressure ulcer for 1 of 2 residents reviewed for pressure ulcers. Following admission and then readmission from a hospital, a resident's pressure ulcer was not routinely assessed, and wound care orders were not immediately obtained for treatment. (Resident B)Finding includes:During record review on 3/9/26 at 10:15 A.M., Resident B's diagnoses included, but were not limited to muscle wasting and atrophy, protein-calorie malnutrition, anemia, and influenza. Resident B's most recent admission Minimum Data Set (MDS) assessment, dated 12/26/26, indicated the resident admitted to the facility with no unhealed pressure ulcers, was at risk for developing pressure ulcers, and was dependent for mobility, including rolling in side to side in bed. A Braden scale assessment (tool used to predict the risk for developing pressure ulcers), completed 1/10/26, indicated Resident B was at low risk for developing pressure ulcers. Resident B's physician orders included, but were not limited to, cleanse coccyx with wound cleanser, pat dry, cover with foam dressing (started 1/16/26 and discontinued 1/20/26), cleanse area to coccyx with wound cleanser, pat dry and apply border foam dressing (started 2/9/26 and discontinued 2/19/26).Resident B's care plan included, but was not limited to, resident has alteration in skin integrity: unstageable pressure injury (initiated 1/10/26). Interventions included but were not limited to; evaluate and change treatment as needed, observe and report any new concerns for evaluation and/or treatment changes or interventions, and observe skin per facility policy and with routine care.Resident B's weekly wound evaluation, dated 1/10/26 (Admission), included an initial wound assessment for Resident B's coccyx: Stage 1 pressure ulcerMeasurement: 7 centimeters (cm) length (L) x 4 cm width (W) x 0 cm depth (D)No drainage or exudateCurrent treatment: Not available (N/A)Date treatment ordered: N/AWound status/ Additional comments: Resident has redness on coccyx with a small open wound more toward the right buttocks. Wound nurse should look at it and give ideas to help with healing.Resident B's nurse's progress notes included, but were not limited to:1/10/26 at 8:33 A.M. - Post Admission/ readmission - skin condition: small open lesion on coccyx with surrounding redness and irritation. 1/12/26 at 1:03 A.M. - Post Admission/ readmission - skin condition: open lesion. Summary note: Resident is resting in room. Resident seemed very tired. Resident indicated she needs to sleep on her side because she has a bedsore. Resident B was admitted to the hospital on [DATE]. Resident B discharged from the hospital on 1/21/26 and returned to the facility.Resident B's hospital wound / ostomy evaluation dated 1/17/26 at 2:01 P.M., indicated the reason for consult was, Wound to buttocks on arrival. Was on last admission also (last admission was prior to facility admission on [DATE])Wound: unstageable pressure injury (present on arrival)Dimensions: 1.7 cm (L) x 0.4 cm (W) x 0.1 cm (D)Wound bed: 100% sloughPeri-wound skin: small pinpoint open area with pink moist tissue distal to larger area, presenting as stage 2 pressure injury (present on arrival).Drainage: scant serosanguinousNo signs or symptoms of infection. A facility admission / readmission assessment dated [DATE] at 4:36 P.M., included:Pressure ulcer to sacrumMeasurements: 1 cm (L) x 0.3 cm (W) x 0.1 cm (D)A nurse's progress note dated 2/6/26 at 3:20 A.M., indicated during a skin check, a wound on the coccyx was found by the nurse. A risk assessment was being submitted due to the wound. A wound assessment report, dated 2/18/26 included:Location: CoccyxMeasurements: 1 cm (L) x 0.5 cm (W) x 0.2 cm (D)Etiology: Pressure Ulcer / InjuryStage / Severity: UnstageableDate acquired: 1/21/26 (present on admission)% Granulation: 20% granulation% Slough: 80% sloughExudate amount: ModerateExudate description: Serosanguineous A wound assessment report, dated 2/25/26 included:Location: CoccyxMeasurements: 1 cm (L) x 0.5 cm (W) x 0.2 cm (D)Etiology: Pressure Ulcer / InjuryStage / Severity: UnstageableDate acquired: 1/21/26 (present on admission)% Granulation: 30% granulation% Slough: 70% sloughExudate amount: ModerateExudate description: Serosanguineous A wound assessment report, dated 3/4/26 included:Location: CoccyxMeasurements: 1.1 cm (L) x 0.7 cm (W) x (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Waters of Rockport Skilled Nursing Facility, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 815 W Washington St Rockport, IN 47635	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	0.2 cm (D)Etiology: Pressure Ulcer / InjuryStage / Severity: UnstageableDate acquired: 1/21/26 (present on admission)% Granulation: 20% granulation% Slough: 80% sloughExudate amount: ModerateExudate description: Serosanguineous Resident B's Medication Administration Record (MAR) / Treatment Administration Record (TAR) from the admission date of 1/10/26 through February, 2026 indicated the resident did not receive routine wound treatment or have an order for routine wound treatment to the coccyx from 1/10/26 to 1/14/26 (discharged to hospital). Upon readmission on [DATE], Resident B did not receive routine wound treatment or have an order for routine wound treatment to the coccyx from 1/21/26 through 2/8/26.During an interview on 3/10/26 at 12:05 P.M., LPN 4 indicated initial admission or readmission wound assessments should trigger the nurse to obtain a wound treatment order. The wound care nurse would then complete weekly wound assessments. During an interview on 3/10/26 at 12:10 P.M., RN 6 indicated Resident B's coccyx wound assessments were not documented following the resident's readmission from the hospital on 1/21/26 until 2/18/26. On 3/10/26 at 12:20 P.M., the DON supplied a facility policy titled, Guidelines for Prevention/Treatment of Pressure Injuries, dated 10/9/23. The policy included, .Objectives: In accordance with Federal Regulations-and based on resident assessment, the facility will ensure: .2) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.This citation relates to intake 2785193. 410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(2)