STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155483	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Rising Sun, The	405 Rio Vista LN Rising Sun, IN 47040

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to operate the facility van lift safely and appropriately for 1 of 3 residents reviewed for accidents. (Resident D)Findings include:During an interview, on 11/20/2025 at 10:13 A.M., Resident D indicated recently she was getting out of the facility van with a staff member when the van lift felt like it gave out and went straight to the ground. Her wheelchair tipped back, and she fell to the ground. There wasn't a staff member standing on the lift when it went down. She didn't hit her head when she fell, but she did hurt her upper back that now has some bruising, and she was very sore. She did have to go to the hospital, but she didn't break any bones or have any bleeding anywhere. Just the bruising to her back. During an observation, on 11/20/2025 at 10:44 A.M., two staff members went into Resident D's room to assist her with repositioning. The resident was rolled to her right side. She had a baseball sized bruise to her upper left back. During an interview, on 11/20/2025 at 11:00 A.M., Activities/Transport Driver 2 indicated she was not the staff member that was operating the van at the time of the incident with Resident D. She wasn't sure what happened, but she had a video call with a representative with the van lift company on Monday. When they spoke with him, he indicated that the lift would not have been able to drop the resident like they said it did. The lift had been working correctly ever since the incident and was put back into service. During an observation and interview, on 11/20/2025 at 11:05 A.M., Activities/Transport Driver 2 demonstrated that the van lift was operational without issue. There was a safety belt on the back of the lift and Activities/Transport Driver 2 indicated it was to prevent residents from going out of the lift or falling backwards. During an interview, on 11/20/2025 at 11:09 A.M., the Administrator indicated on 11/15/2025 Activities/Transport Driver 3 was taking Resident D out of the van using the van lift when she backed her out on the lift and the lift just went down. They attempted to recreate the event and the only time they were able to get the lift to drop down was when the lift wasn't flush with the van. They believe the incident was a user error. They had annual training for staff with a representative from the van lift company and he was contacted on Monday, 11/17/2025. He told them there were only two situations that would have caused the lift to drop fast and that was that the resident was either pushed out, or the lift wasn't positioned where it needed to be. The staff that operate the van lift have been in-serviced since the incident occurred. During an interview, on 11/20/2025 at 12:17 P.M., the representative for the van lift company indicated he spoke with the facility on Monday, 11/17/2025. He wasn't quite sure what happened as he wasn't there when the incident occurred. He was told that the transport person rolled the resident's wheelchair onto the lift and the lift dropped suddenly to the ground. The lift safety belt was not in place. He informed them that it was not possible for the lift to drop to the ground suddenly without the hydraulics going out of the lift. The lift would not be back into operation with the hydraulics going out if they didn't get them repaired. The lift was fully operational when he observed it through a video call on Monday. During an interview, on 11/20/2025 at 12:22 A.M., the Maintenance Director indicated he was the weekend manager on Sunday, 11/16/2025. When he came in the staff informed him that the van lift had broken the previous day and a resident had fell to the ground. He was told that Activities/Transport Driver 3 was pushing Resident D out of the van onto the lift when (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the lift suddenly went to the ground, causing both the resident and staff member to fall to the ground. The safety belt on the lift was not in place at the time of the transfer and should be in place before the lift was even folded down. He performed monthly inspections of the van and lift without any concerns from the last two months. The only documented inspections for the van lift provided were dated 10/15/25 and dated 11/12/25. During an interview, on 11/20/2025 at 1:04 P.M., RN 4 indicated she was the nurse on duty on 11/15/2025 when Activities/Transport Driver 3 came into the facility for help because Resident D was on the ground outside. When she went outside Resident D was lying on the ground on her right side. The resident's wheelchair was sitting on the van lift on its back with the lift all the way on the ground and the lift strap not in place. Activities/Transport Driver 3 had told her she didn't have time to put the strap in place before the lift went to the ground. The resident was complaining of back and right elbow pain at the time. She assessed the resident and started neurological assessments. She made the resident comfortable and someone called 911. The resident was transported to the local hospital. The resident had no abnormal findings and was sent back to the facility. The clinical record for Resident D was reviewed on 11/20/2025 at 10:35 A.M. A Quarterly Minimum Data Set assessment, dated 10/20/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, heart failure, hypertension, renal insufficiency, anxiety, and depression.A Progress Note, dated 11/15/2025 at 3:21 P.M., indicated the writer was notified by the facility's transporter that Resident D was on the ground outside. The writer went to the parking lot, and the resident was lying on her right side on the ground at the back of the van. The staff member was transferring the resident and when she was putting the resident onto the lift from the van the hydraulics failed causing the lift, staff member, and the resident to quickly lower to the ground and they both fell off the lift. A head-to-toe assessment was completed; neurological assessments were completed. The resident was alert and complained of back and head pain. An ambulance was called, and the resident was sent to the local emergency room for evaluation and treatment. A Progress Note, dated 11/16/2026 at 2:04 A.M., indicted the resident returned from the hospital and the x-rays were negative. The hospital records for the resident lacked abnormal findings related to the fall. The current, undated, facility policy titled, Vehicle Lift Safety, was provided by the Regional Director of Operations on 11/20/2025 at 12:57 P.M. The policy indicated, .Resident will be secure and safe during use of transport vehicle lift.Secure seat belt.The current facility policy titled, GUIDELINES FOR INCIDENTS/ACCIDENTS/FALLS, dated 06/30/2023, was provided by the Regional Director of Operations on 11/20/2025 at 12:57 P.M. The policy indicated, .The facility will ensure that incidents and accidents that occur involving residents are identified, reported, and resolved.3.1-45(a)(1)3.1-45(a)(2)