STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Scottsburg, The	1350 N Todd Dr Scottsburg, IN 47170

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to ensure a resident was free from physical restraint for the purpose of convenience for 1 of 3 residents reviewed for restraints. (Resident B)Findings include:The record for Resident B was reviewed on 7/31/25 at 9:48 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, asthma, alcohol abuse with alcohol induced mood disorder, muscle weakness, abnormalities of gait and mobility, and anxiety disorder.The care plan, dated 7/8/25 and revised on 7/28/25, indicated Resident B was at risk for falls due to and a history of falls, weakness, impaired mobility, and restlessness. The interventions included, but were not limited to, a high back wheelchair for comfort and positioning as tolerated, staff were to keep the resident's call light in reach, and staff were to keep the resident within sight of staff when he was up in his wheelchair.The incident report, dated 7/28/25, indicated Certified Nursing Aide (CNA) 3 reported to oncoming staff that staff had to use a gait belt in the wheelchair to keep the resident from faceplanting because he kept trying to get up.During an interview, on 7/31/25 at 11:00 a.m., the Administrator indicated the incident with Resident B happened the night before, on 7/27/25 around 8:00 p.m. There was a death in the facility and staff were getting the resident cleaned up for the funeral home. CNA 4 indicated to the next shift that she had to put a gait belt around Resident B and his chair to keep him from falling. The CNA confirmed to the Administrator that she restrained the resident for his safety because they were busy with another resident. The resident was restrained for approximately 15 minutes. She did not restrain the resident because she was upset with the resident, she did it for his safety and indicated she did not know it was considered abuse. The CNA had been educated on abuse and restraints were included in the in-service.During an interview, on 7/31/25 at 11:45 a.m., CNA 4 indicated she was the CNA for the day shift when the incident occurred. CNA 3 approached her and indicated she had to put a gait belt restraint around Resident B so he would not faceplant onto the floor. CNA 4 indicated to CNA 3 she could not restrain the resident for any reason and informed the nurse on duty and the Director of Nursing (DON). During an interview, on 7/31/25 at 12:00 p.m., Licensed Practical Nurse (LPN) 5 indicated she entered the facility at 5:30 a.m., on 7/28/25 for the day shift. She heard the day shift, and the night shift CNAs say something about restraining a resident. She asked the CNAs what they were talking about and CNA 4 indicated the night shift CNA 3 told her that she had to restrain Resident B so he would not faceplant. She informed CNA 3 she could not restrain any resident. CNA 4 returned to the nurse's station with the resident's wheelchair and the gait belt was still attached to the wheelchair in a restraining position. The DON was notified immediately about the incident. She had no knowledge of how long the restraint was on the resident. During an interview, on 7/31/25 at 12:27 p.m., the Social Service Director indicated she was currently working on the 3 day follow up on the incident with the gait belt. She conducted her follow ups on 7/29/25, 7/30/25, and 7/31/25. The care plan was updated on 7/29/25. The resident was pleasantly confused and was verbal, but she couldn't understand what he was saying. When the incident occurred, the staff member was trying to keep the resident from falling, sliding, or leaning by using a gait belt around the resident and the wheelchair. The resident did lean at times. The resident had not shown any signs of effects from the incident. The current abuse prevention policy, dated 10/22, indicated .the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being .This deficient practice was corrected prior to the start of the survey, on 07/28/25, after the facility assessed residents, educated staff, and had a system of monitoring in place. 3.1-3(w)3.1-26