

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Waters of Scottsburg, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident was evolved in aspects of his care related to a room change, and the temporary removal of his cell phone, from his possession without his consent, for 1 of 3 residents reviewed for the right to make treatment decisions. (Resident B) Findings include: The clinical record for Resident B was reviewed on 1/8/26 at 2:28 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease, major depressive disorder, bipolar and anxiety. The 11/25/25 quarterly MDS (Minimum Data Set) assessment indicated Resident B had intact cognition. The care plan, dated 5/20/25, indicated Resident B enjoyed independent activities, walking and being outdoors. The care plan, dated 8/30/25, indicated Resident B resided on the secured unit related to dementia and exit seeking behaviors. The physician's order, dated 5/17/25, indicated staff were to monitor behaviors every shift for anxiety and depression. On 1/8/26 at 1:16 p.m., the resident was observed sitting on his bed in his room in the memory care unit. The resident was well groomed and alert and oriented to person, place, time and situation. Resident B indicated he did not know why he was placed on the secured memory care unit. One day he had walked out on the front porch to sit and get some fresh air and had done so multiple times before. There was another person out there. A staff member came out and told him to come back in. He was told that he did not ask for permission to go outside and that he broke the rules. He told the staff member he did not realize he had to ask to go outside and did not know of any rules. After that, the staff put a monitor on his ankle. About a week later they moved him back here (memory care unit). No one asked him, they just moved him. They also took his phone. He, himself, did not give permission for his phone to be kept at the nurse's station or to move back here. He does have his phone back now. He feels like he has no freedom and is being held prisoner. He would prefer to be where there were higher functioning people. The progress note, dated 7/9/25 at 4:33 p.m., indicated Resident B was observed walking down the hallway with his walker. The resident went to the front doors and took himself outside. The resident did not let staff know that he wished to exit the building. Staff went outside and got the resident without incident. The physician's order, dated 7/11/25, indicated the resident was to have a wander guard to the left wrist due to his risk for elopement. The Social Services note, dated 7/17/25 at 10:39 a.m., indicated an attempt was made to contact Resident B's spouse to discuss exit seeking, elopement risk and room move. There was no answer and a text message was sent. The Social Services note, dated 7/18/25 at 7:31 a.m., indicated Resident B's exit seeking and impulsive behaviors were discussed with his spouse. The spouse was agreeable with a room change. The IDT (interdisciplinary team) note, dated 7/18/25 at 9:03 a.m., indicated Resident B was reviewed for impulsive behaviors, restlessness and exhibiting manic behaviors. The resident also recorded staff on his cell phone. The behavior note, dated 7/18/25 at 10:28 a.m., indicated the resident had attempted to leave the building and threatening to video staff on his phone. Review of the behavior tracking log on 7/18/25 dayshift indicated the resident had behaviors of either anxiety or</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 155494
		If continuation sheet Page 1 of 4

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>depression with effective interventions. The Social Services note, dated 7/18/25 at 11:32 a.m., indicated Resident B was moved to the memory care unit for safety related to exit seeking. The resident's family members met with the IDT team and were all in agreement. The resident was to see the psychiatrist at next visit related to increased anxiousness and manic episodes. Resident B's wander guard was removed. The resident toured the unit, introduced him to his roommate and visited with family. The physician's order, dated 7/18/25, indicated to discontinue the wander guard. The IDT note, dated 7/19/25, indicated on 7/18/25, the resident's family members were all aware of the resident's behaviors of anxiousness, pacing, exit seeking and manic. All were agreeable for the resident's cell phone to be kept at the nurse's station until he wants to use it. The family were aware that all snacks and drinks were to be locked on the unit pantry due to the risk of choking of other residents who may wander. The progress note, dated 7/19/25 at 4:04 p.m., indicated the resident returned from dialysis and the resident and Family Member 4 came to the desk wanting the resident's cell phone and charger. Both the resident and family member were aware of why the resident was not in possession of the items. The resident was placed into this unit about 24 hours ago and the family member were not sure why the resident was on the unit. Staff tried to explain things to both the resident and family member who felt the resident was being centered out. The phone and charger were returned to the nurse's station at this time. The physician's order, dated 7/19/25, indicated staff were to monitor behaviors every shift for auditory hallucinations, manic, pacing fast with walker, making non-valid comments, verbal aggression and depression The progress note, dated 7/23/25 at 11:45 a.m., indicated Resident B stated it was unknown why he had been moved to the new unit for behaviors. The resident denied confusion and no recall of it prior to the change for rooms. Review of the June 2025 and July 2025 behavior tracking logs lacked documentation of any attempts by Resident B to exit the facility or display impulsive behaviors, anxiousness, pacing, restlessness or manic behaviors. The progress notes lacked documentation of conversations with Resident B regarding the room move or permission from the resident for the staff to remove the resident's phone from his possession. During an interview, on 1/9/26 at 1:30 p.m., the Social Services Designee (SSD) indicated the resident was placed on the memory care unit due to his exit seeking and the wander guard that was placed had been ineffective. The resident continued to exit seek after a wander guard was placed. The SSD and the IDT determined the placement of the resident on the memory care unit and the family agreed. She had not spoken to the resident about the move or his phone and was unsure if any of the other IDT members had. The resident's behaviors and exit seeking should be on the behavior logs. The behavior logs for June 2025 and July were reviewed with the SSD with no documentation of exit seeking. The SSD indicated the nursing staff do not document as they should. On 1/9/26 at 12:27 p.m., the Administrator provided a current copy of the document titled Resident Rights dated 1/6/2020. It included, but was not limited to, Policy. It is the policy of the facility to observe and implement RESIDENT RIGHTS as dictated by CMS. These rights and protections are mandated by Federal and state laws. Each resident has the right to be treated with dignity and respect. 3.1-3(a)(1)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on interview and record review, the facility failed to implement, in a timely manner, a plan of care for a resident (Resident B) on the memory care unit for 1 of 3 residents reviewed for care plans. Findings include: The clinical record for Resident B was reviewed on 1/8/26 at 2:28 p.m. The resident's diagnoses included, but were not limited to, bipolar disease and major depressive disorder. The room change notice, dated 7/18/25, indicated Resident B was moved to the memory care unit. The care plan, dated 8/30/25, indicated the resident resided on a secure unit due to dementia and exit seeking. The clinical record lacked documentation of a secured unit base line care plan until 8/30/25 (two weeks after the resident's room change). During an interview, on 1/9/26 at 3:28 p.m., the Director of Nursing indicated Resident B's care plan for the secured unit should have been initiated at the time of the move. On 1/9/26 at 12:27 p.m., the Administrator provided a current copy of the document titled Baseline Care Plan Assessment/Comprehensive Care Plans dated 3/23/21. It included, but was not limited to, Policy. The Comprehensive Care Plan with further expand on the resident's risks, goals and interventions using the Person-Centered Plan of Care approach. that includes measurable goals and timetables to meet the resident's needs. Procedure. As the resident remains in the Nursing Home, additional changes will be mad to the comprehensive care plan based on the assessed needs of the resident. 3.1-35(a)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>Based on interview and record review, the facility failed to ensure a resident (Resident B) placed on the memory care unit had the appropriate diagnosis for placement for 1 of 3 residents reviewed for dementia care. Findings include: The clinical record for Resident B was reviewed on 1/8/26 at 2:28 p.m. The resident's diagnoses included, but was not limited to, diabetes, end-stage renal disease, major depressive disorder, anxiety and bipolar disorder. The physician's order, dated 7/18/25, indicated the resident may reside on the secured unit. The care plan, dated 8/30/25, indicated the resident resided on the secured unit related to dementia and exit seeking. The interventions included activities per schedule, secured unit per physician order and to review and assess appropriate placement. The clinical record lacked documentation for a diagnosis of dementia, Alzheimer's or the clinical need for the secured unit. On 1/9/26 at 12:11 p.m., Resident B's former primary care physician at the facility, indicated the resident did not have a dementia diagnosis and he would not have initiated an order for the resident to be placed on the dementia unit. On 1/9/26 at 12:27 p.m., the Administrator provided a current, undated copy of the document titled Memory Springs. It included, but was not limited to, Admission/Discharge Criteria for Memory Springs. Guidelines for Initial Admission. Individual must have a diagnosis of Alzheimer's or irreversible form of dementia. Individual has been deemed by a physician to be in clinical need of a secured unit. 3.1-37</p>		