Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	04/30/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility management failed to timely report an incident to the Indiana Department of Health when a cognitively impaired resident (Resident B) with a high risk for elopement exited the facility grounds, without supervision, for 1 of 3 residents reviewed for reportable incidents. Findings include:The clinical record for Resident B was reviewed on 4/28/26 at 11:18 a.m. The resident's diagnoses included, but were not limited to, cerebral infarction (stroke), aphasia, cognitive communication deficit and altered mental status. The incident report, dated 4/28/26, indicated on 4/25/26, Resident B attempted to leave the facility, against medical advice, by exiting the front doors. Resident B propelled himself, in his wheelchair, off of the property and fell out of the wheelchair. The admission BIMS (Brief Interview of Mental Status) assessment, dated 4/10/26, indicated the resident had a cognitive impairment. Residents with impaired cognition cannot leave a facility against medical advice. The elopement risk assessment, dated 4/24/26 at 1:23 p.m., indicated Resident B was a high risk for elopement. The care plan, dated 4/24/26, indicated the resident was at risk for elopement related to periods of confusion, inability to verbally express needs and making statements that he wanted to leave and go home. Review of the requested State reportable incidents lacked documentation of Resident B's elopement from the facility. During an interview, on 4/28/26 at 11:25 a.m., the Administrator indicated she had spoken with the corporate team. She was advised to do a re-assessment of Resident B's BIMS score, which was 12 (impaired cognition). Since it was a 12, she was told not to report the incident. During an interview, on 4/29/26 at 8:32 a.m., the Regional Director of Operations indicated the facility follows the State guidance on reporting incidents. On 4/29/26 at 8:49 a.m., the Regional Director of Operations provided a copy of the Indiana Department of Health Policies and Procedures titled Long-Term Care Abuse and Incident Reporting. It included, but was not limited to, Purpose .To facilitate compliance with state and federal law and regulation, as applicable, related to reporting of .incidents in licensed long-term care facilities in Indiana .Elopement .Elopement occurs when a resident without decision making capacity leaves the premises or a safe area without authorization .and/or any necessary supervision to do so OR a resident with decision making capacity leaves the premises or a safe area, without facility knowledge This Citation relates to Intake 2996030 410 IAC (Indiana Authorization Code) 16.2-3.1-28(c)

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 ensure adequate supervision was in place when a resident (Resident B) with impaired cognition and risk for elopement was left outside without staff supervision. This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 4/25/26 when Resident B, with cognitive impairment and elopement risk, propelled himself from the facility grounds to a heavily traveled road where the resident fell out of his wheelchair landing on the pavement in the emergency lane which was 0.2 miles from the facility. The resident was sent to the emergency room and treated for an abrasion to his right foot and right hand. The Executive Director (ED) and Director of Nursing (DON), Regional Director of Operations (RDO) and Regional Nurse Consultant (RNC) were notified of the Immediate Jeopardy on 4/28/26 at 3:33 p.m. Findings include:The clinical record for Resident B was reviewed on 4/28/26 at 11:18 a.m. The resident's diagnoses included, but were not limited to, cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain), right dominant side hemiplegia and hemiparesis (neurological condition affecting one side of the body caused by a brain injury such as a stroke) secondary to a cerebral infarction, cognitive communication deficit (communication impairment) and aphasia (disorder caused by brain damage). The progress note, dated 4/8/26 at 3:35 p.m., indicated the resident was admitted to the facility, the resident was alert to self, unable to understand most things, was able to propel himself in his wheelchair and had a white board for communication. The progress note, dated 4/23/26 at 8:27 p.m., indicated the resident returned from the hospital and a wander guard was placed to his right ankle. The progress note, dated 4/24/26 at 2:25 p.m., indicated the location of the resident's wander guard was changed from the resident's right lower ankle to the left upper wrist. The progress note, dated 4/24/26 at 4:08 p.m., indicated the wander guard was in place to the resident's left wrist. The resident had removed the wander guard once today. The resident was monitored throughout the shift. The care plan, dated 4/24/26, indicated the resident was at risk for elopement related to periods of confusion, the inability to verbally express needs, not wanting to be at the facility and making statements that he was going to leave and go home. The police report, dated 4/25/26 at 7:59 p.m., indicated a call was received for a medical issue on a busy road 0.2 miles from the facility. The hospital emergency department record, dated 4/25/26 at 9:00 p.m., indicated the resident presented to the emergency department after eloping and flipping out of his wheelchair. The resident was non-verbal, had a history of a stroke and had abrasions on his right foot and right hand. The IDT (interdisciplinary team) note, dated 4/27/26 at 3:57 p.m., indicated the following:-Resident had demonstrated a consistent pattern of expressing a desire to leave the facility, which included gesturing and behaviors indicative of exit-seeking-On 4/19/26, the resident left the faciity on LOA (leave of absence) with a family friend. The resident did not return until the next day. Upon return, the resident initially refused to exit the vehicle and required assistance and EMS (emergency medical services). The resident was sent to the hospital for evaluation and returned to the facility the following day.-The resident continued to express his desire to leave the facility and exhibited ongoing exit-seeking behaviors.-The resident was later (4/25/26) identified off facility grounds and at approximately 8:06 p.m., was located on the roadside. The resident was evaluated and observed to have an abrasion to the right foot and hand. The incident report, dated 4/28/26, indicated Resident B attempted to leave the facility on 4/25/26 by exiting the front doors and propelling himself off the property. The resident fell out of his wheelchair. During an observation, on 4/29/26 at 8:50 a.m., Resident B was observed with an abrasion to the right palm, between the thumb and forefinger. The second toe and fourth toe of the right foot had one small, scabbed area. The right great toe had an abrasion that measured 1.2 cm (centimeters) in width and 3 cm in length. During an interview, on 4/28/26 at 11:07 a.m., the Director of Nursing indicated on 4/25/26 at 6:00 p.m., a group of residents, including Resident B, were sitting on the front porch. There were two staff from the oncoming night (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	shift Certified Nursing Assistants (CNA 5 and CNA 6), who were sitting outside at a table prior to the start of their shift when the residents had come out to the front porch. Activity Aide 7 had walked out of the facility after clocking out and sat at the table waiting for her ride home. CNA 5 and CNA 6 went inside the facility to clock in for work. CNA 5 and CNA 6 were unaware the Activity Aide 7 had clocked out to go home and was waiting for her ride home. At 6:45 p.m., Qualified Medication Aide (QMA) 9 exited the facility through the front doors and did not see any residents or staff outside at that time. Speech Therapist 8 had left the facility for the evening and, at 8:06 p.m., notified the facility of the resident's elopement. During an interview on 4/29/26 at 1:18 p.m., Speech Therapist 8 indicated she had left the facility at around 8:00 p.m. on 4/25/26. When she had gotten up to the main road, she planned to turn right. She looked to the left and then turned right onto the road, however, she turned around in a parking lot on the left side of the road because she had seen a person lying on the side of the road. She pulled up and had gotten out of her car where she saw two middle-aged men and a woman. The two men had gotten the male up off of the ground and into his wheelchair. She spoke to one of the gentlemen who reported that he had called 911. She asked the gentleman if she could speak with the male to make sure it was not a resident from where she worked. She asked the male if she could take a picture of him and he shook his head yes. She took the picture and sent it to her manager and asked if the resident belonged to their facility. Her manager sent her a text back and told her he was a resident of the facility. EMS and the police had arrived by then. Not long after that, multiple staff members from the facility had gotten to the scene. During an interview, on 4/29/26 at 3:29 p.m., Activity Aide 7 indicated on 4/25/26, she had been sitting outside waiting for a ride and there were residents outside. When she left at 6:00 p.m., Resident B was still sitting outside. Activity Aide 7 was unaware that Resident B was an elopement risk. On 4/28/26 at 1:18 p.m., the Administrator provided a current, undated copy of the document titled Policy and Procedure Regarding Missing Residents and Elopement. It included, but was not limited to, Policy Statement.It is the policy of this facility that all residents are provided adequate supervision to meet each resident's nursing and personal care needs. The past non-compliance Immediate Jeopardy that began on 4/25/26. The Immediate Jeopardy was removed and corrected by 4/26/26 after the facility implemented a systemic plan that included the following actions: All staff were educated on the elopement policy and procedure with emphasis an elopement prevention (4/25/26); Elopement assessments were completed on all residents residing in the facility and care plans updated as needed (4/25/26); Elopement binders were updated and current (4/25/26); Implementation of weekly reviews of elopement risk assessments for four weeks, then monthly for five months to ensure any resident with high risk scores have appropriate safety precautions in place (4/26/26). This Citation relates to Intake 2996030 410 IAC (Indiana Administrative Code) 3.1-45(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to ensure catheter care was in place for a resident (Resident C) with an indwelling catheter for 1 of 1 residents reviewed for urinary catheters. Findings include:The clinical record for Resident C was reviewed on 4/29/26 at 12:07 p.m. The resident's diagnosis included, but was not limited to, Stage 4 pressure ulcer (severe, full thickness wound involving extensive tissue loss, exposing muscle, tendon or bone) to the sacrum. On 4/29/26 at 8:50 p.m., the resident was observed with an Indwelling urinary catheter in place. The physician's order, dated 4/8/26, indicated the resident was to receive catheter care every shift. The clinical record lacked documentation of catheter care provided to the resident between 4/9/26 and 4/29/26. During an interview, during the survey period, Staff Member 13 indicated indwelling urinary catheter care should be provided every shift and documented. On 4/30/26 at 4:00 p.m., the Regional Director of Operations provided a current copy of the document titled Guidelines for Indwelling Foley Catheter Care dated 10/16/24. It included, but was not limited to, Purpose.The main purpose of proper indwelling foley catheter care is to prevent catheter associated urinary tract infections. Trained clinical staff.will conduct indwelling foley catheter care. This Citation relates to Intake 2996274 410 IAC (Indiana Authorization Code) 16.2-3.1-41(2)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on interview and record review, the facility failed to ensure a resident's (Resident C) IV (intravenous) antibiotic therapy was reflected on the medication administration record, as ordered by the physician, for 1 of 3 residents reviewed for IV medication administration. Findings include:The clinical record for Resident C was reviewed on 4/29/26 at 12:07 p.m. The resident's diagnosis included, but was not limited to, osteomyelitis (a serious bone infection causing inflammation and potential tissue death, usually triggered by bacteria spreading from nearby wounds, surgery, or the bloodstream). During an observation, on 4/29/26 at 8:50 a.m., Resident C was observed with a PICC (peripherally inserted central catheter) line to the right upper extremity. The physician's order, dated 4/8/26, indicated the resident was to receive Vancomycin (A powerful antibiotic used to treat serious infections) HCl (hydrochloride) 1.25 grams, intravenously two times a day at 8:00 a.m. and 8:00 p.m. for osteomyelitis. The April 2026 medication administration record lacked documentation of the administration of the antibiotic at 8:00 a.m. on 4/23/26 and 4/27/26. The physician's order, dated 4/20/26, indicated the resident was to receive Cefazolin Sodium (antibiotic used for bone/joint infections) 2 grams, intravenously, every 8 hours at 6:00 a.m., 2:00 p.m. and 10:00 p.m. for osteomyelitis. The April 2026 medication administration record lacked documentation of the administration of the antibiotic on 4/23/26 at 2:00 p.m. During the survey period, Staff Member 14 indicated the medication administration record should be signed off by the nurse administering the medication. On 4/30/26 at 4:00 p.m., the Regional Director of Operations provided a current, undated copy of the document titled Medication Administration Guidelines. It included, but was not limited to, The Right Documentation.Sign MAR immediately after administering the medications. This Citation relates to Intake 2996274 410 IAC (Indiana Authorization Code) 16.2-3.1-47(a)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interview and record review, the facility failed to ensure behavior monitoring was in place for a resident (Resident B) with exit-seeking behaviors for 1 of 3 residents reviewed for behaviors. Findings include:The clinical record for Resident B was reviewed on 4/28/26 at 11:18 a.m. The resident's diagnoses included, but were not limited to, cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain) and cognitive communication deficit (communication impairment).The care plan, dated 4/24/26, indicated the resident was at risk for elopement related to periods of confusion, unable to verbally express needs, making statements that was going to leave and go home and did not want to be at facility. The IDT (interdisciplinary team) note, dated 4/27/26 at 3:57 p.m., indicated the following:-Resident had demonstrated a consistent pattern of expressing a desire to leave the facility, which included gesturing and behaviors indicative of exit-seeking-On 4/19/26, the resident left the faciity on LOA (leave of absence) with a family friend. The resident did not return until the next day. Upon return, the resident initially refused to exit the vehicle and required assistance and EMS (emergency medical services). The resident was sent to the hospital for evaluation and returned to the facility the following day.-The resident continued to express his desire to leave the facility and exhibited ongoing exit-seeking behaviors.-The resident was later (4/25/26) identified off facility grounds and at approximately 8:06 p.m., was located on the roadside. The clinical record lacked documentation of the implementation of behavior tracking monitoring for the resident's exit-seeking behaviors. During the survey period, Staff Member 17 indicated the resident had exit-seeking behaviors prior to the day he had eloped. During an interview, on 4/30/26 at 12:16 p.m., the Social Services indicated Resident B should have behavior monitoring in place for exit-seeking behaviors. On 4/30/26 at 12:41 p.m., the Regional Director of Operations provided a current copy of the document titled Behavior Management Program dated 5/20/24. It included, but was not limited to, Purpose.Each resident of the facility identified as exhibiting problematic behavior will be observed in a manner to identify the casual factor, if possible, of the behavior as well as seek approaches/interventions appropriate for the same.Policy.It is the policy of this facility to assess those residents exhibiting problematic behavior.Initiation of Behavior Management Logbook.The record should list behaviors and interventions specific to the resident.Procedure.Each resident who exhibits problematic behaviors will have a form for monitoring his/her status. This Citation relates to Intake 2996030 410 IAC (Indiana Authorization Code) 16.2-3.1-37