STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Tipton Skilled Nursing Facility, The	300 Fairgrounds Rd Tipton, IN 46072

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the physician when a resident sustained an injury during a transfer for 1 of 3 residents reviewed for notification of change. (Resident B) Findings include: During a telephone interview, on 6/16/25 at 9:43 a.m., Resident B's family member indicated Resident B had to be sent to the emergency room. The facility reported the resident had a skin tear, but it was a laceration which required seven staples. The family was not notified until Resident B was sent to the hospital. During an observation, on 6/16/25 at 9:27 a.m., Resident B had a wound on the outer aspect of her lower left leg. The wound was approximately two centimeters long and closed with six staples. It was bruised around the area. The clinical record for Resident B was reviewed on 6/16/25 at 9:40 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, unsteadiness on feet, and muscle weakness. A facility document, titled Skin Tear, dated 6/10/25 at 9:50 p.m., LPN 3 notified the on-call physician on 6/10/25 at 10:14 p.m. A Nurse Practitioner progress note, dated 6/11/25, indicated .Skin tear occurred on evening shift and nursing wrote that writer/on call was notified, however on call not notified and write (writer) not aware until day shift nurse informed writer During a telephone interview, on 6/16/25 at 11:18 a.m., LPN 3 indicated she called the family and contacted the on-call physician. She used her cell phone. The facility only had one tablet which had an application for contacting the on-call provider and it was easier to use her cellular phone than find the tablet. During a telephone interview, on 6/12/25 at 12:43 p.m., Nurse Practitioner (NP) 7 indicated she did not know why the nurse did not send the resident to the hospital at the time of the incident. The on-call provider was not notified. NP 7 was aware that LPN 3's documentation indicated the on-call was notified. If the on-call provider had been notified, NP 7 would have received notes even if the note was in a draft form and there were no notes published. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the exit conference, on 6/17/25 at 11:44 p.m., the Director of Nursing indicated the facility expected accurate documentation in the resident's records. A current facility policy, titled Change in Resident's Condition or Status, undated and received from the Executive Director on 6/16/25 at 1:55 p.m., indicated .The nurse will notify the resident's attending physician when .The resident is involved in any accident or incident that results in injury This citation relates to Complaint IN00461426. 3.1-5(a)(1)

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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 - 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 ensure a resident was kept safe during a transfer for 1 of 1 resident reviewed for accidents. (Resident B) Findings include: During a telephone interview, on 6/16/25 at 9:43 a.m., Resident B's family member indicated Resident B had to be sent to the emergency room. The facility reported the resident had a skin tear, but it was a laceration which required seven staples. During an observation, on 6/16/25 at 9:27 a.m., Resident B had a wound on the outer aspect of her lower left leg. The wound was approximately two centimeters long and closed with six staples. It was bruised around the area. During an observation, on 6/17/25 at 10:33 a.m., with LPN 6, the bed frame was observed to be covered with sheep skin. The edges under the sheep skin covering felt rounded along the frame and at the joints where the frame connected. The underside was found to have metal bolts, but they did not stick out and were inside of the bed frame. There was no area on the bed frame found sticking out. The bed frame had no sharp edges. A facility reported incident (FRI), dated 6/10/25 at 9:01 p.m., indicated Resident B was being transferred to bed when her lower left leg rubbed the bed frame and caused a skin tear. Resident B was transported to the hospital and returned with staples. The clinical record for Resident B was reviewed on 6/16/25 at 9:40 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, unsteadiness on feet, and muscle weakness. A quarterly Minimum Data Set (MDS) assessment, dated 3/17/25, indicated Resident B was severely cognitively impaired and she required substantial to maximum assistance when moving from sitting to standing position. During an interview, on 6/16/25 at 10:45 a.m., LPN 6 indicated Resident B was a two person transfer and pretty much always required a gait belt. During an interview, on 6/16/25 at 10:54 a.m., Certified Occupational Therapy Assistant 5 indicated the resident was currently on the therapy case load. On 6/3/25, Resident B was a total assist with two staff members for standing, transferring, and was not walking. The resident's occupational evaluation indicated her sitting balance was poor, she was a total transfer with maximum assistance of two staff. Certified Occupational Therapy Assistant 5 indicated all staff should use a gait belt unless the resident required a mechanical lift or did not require assistance (independent). During a telephone interview, on 6/16/25 1254 p.m., CNA 2 indicated she and CNA 1 transferred Resident B. She was on one side of Resident B holding her arm and CNA 1 was on the other side of Resident B holding her arm. She thought the resident's leg got caught on bed, but she was not sure where. She did try to find the area and thought it was from where the metal on the bed connected. The resident was tired and had just woken up. Resident B was dead weight and could not move herself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview, on 6/16/25 at 1:08 p.m., CNA 1 indicated she and CNA 2 went to put Resident B in bed. Resident B was dead weight, a rough transfer. When they turned Resident B to the bed, the resident asked if her leg was bleeding. CNA 1 looked and noticed blood. CNA 1 indicated the footrests had been removed from the wheelchair, then each CNA hooked their arms under Resident B arm pits and used the waist of the resident's pants to transfer her. CNA 1 indicated Resident B was not good at standing in general. Resident B was normally a two person transfer which was done by holding the resident's pants and using arms under Resident B's armpits. CNA 1 indicated the facility did have a gait belt policy, but she had not read it. During an interview, on 6/17/25 at 9:02 a.m., the Director of Nursing (DON) indicated gait belts were used for residents depending on if it was appropriate for use. CNAs were educated on transferring residents. The DON indicated she would need to inquire with therapy on if transferring residents by placing arms under the arm pit and using the waist of the resident's pants or belt loops was appropriate. During an interview, on 6/17/25 at 10:11 a.m., the Director of Nursing indicated a two person transfer with a gait belt was the appropriate way to transfer Resident B. During an interview, on 6/17/25 at 11:38 a.m., the Corporate Support Nurse indicated the facility did not have a step by step transfer procedure. A current facility policy, titled Transfer Belts/Gait Belts, undated and received from the Executive Director on 6/16/25 at 1:55 p.m., indicated .It is the intent of the facility to promote safety in transferring and ambulating resident, a gait belt .A gait belt is used as indicated for safety by the person qualified to transfer the Resident . Gait belt should be placed over the resident's waist over clothing .The resident is transferred by grasping the secured gait belt to provide stability and balance during movement This citation relates to Complaint IN00461426. 3.1-45(a)(1) 3.1-45(a)(2)