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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview and record review, the facility failed to ensure neurological assessments were completed and documented after an unwitnessed fall for 1 of 2 residents reviewed for quality of care. (Resident B)Findings include:During a telephone interview, on 6/29/26 at 9:48 a.m., an anonymous interviewee indicated neurological checks and fall follow-up monitoring were not completed for Resident B.During an observation and interview, on 6/29/26 at 10:05 a.m., Resident B's right arm was noted to be in a sling. The clinical record for Resident B was reviewed on 6/29/26 at 10:58 a.m. The diagnoses included, but were not limited to, dementia, heart failure and weakness.A nursing progress note, dated 6/10/26 at 5:45 p.m., indicated Resident B complained of right upper extremity/shoulder pain. The physician and family were notified and an x-ray was ordered.A nursing progress note, dated 6/11/26 at 9:54 a.m., indicated Resident B had reported to the nurse she had fallen out of bed and had complaints of pain/discomfort to the right arm. The x-ray revealed an impacted and displaced fracture of the upper end of the humerus (upper arm bone).The clinical record did not contain documentation follow-up assessments and neurological checks had been completed for 72 hours after the unwitnessed fall.The last 72-hour fall follow-up assessments were charted in March 2026.During an interview, on 6/30/26 at 9:25 a.m., LPN 2 indicated when a resident had an unwitnessed fall, fall follow-up assessments and neurological checks needed to be completed for 72 hours.During an interview, on 6/30/26 at 12:09 p.m., the Executive Director indicated the facility did not have documentation neurological checks for Resident B were completed.A current facility policy, titled NEURO CHECKS, undated and received from the Executive Director on 6/30/26 at 11:54 a.m., indicated .Neuro checks will be performed for a minimum of 72 hours post incident.ALWAYS DO NEURO CHECKS IF THE FALL WAS UNWITNESSED.EVEN IF THE RESIDENT THEMSELVES.STATE THAT THE RESIDENT WHO FELL DID NOT HIT THEIR HEAD BEFORE AFTER OR DURING THE FALL.Observe the resident for the first 72 hours.This citation relates to Intake 3045109.410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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 - 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 interview and record review, the facility failed to ensure a resident was transferred according to her plan of care, was free from an injury of unknown origin, and the investigation into the injury contained complete documentation for 1 of 2 residents reviewed for accidents. (Resident B) This deficient practice resulted in Resident B receiving a mildly impacted and displaced fracture of the proximal right humerus (the ball-shaped upper portion of the arm bone which forms the shoulder joint).Findings include:During a telephone interview, on 6/29/26 at 9:48 a.m., an anonymous interviewee indicated Resident B was injured in the shower. The facility indicated she fell out of bed. Resident B did not fall out of bed.During an observation, on 6/29/26 at 10:05 a.m., Resident B's right arm was noted to be in a sling. The clinical record for Resident B was reviewed on 6/29/26 at 10:58 a.m. The diagnoses included, but were not limited to, dementia and weakness.A care plan, dated 12/9/25, indicated Resident B had impaired cognition/function or impaired thought process related to dementia. Interventions included, but were not limited to, ask yes or no questions to determine needs and to present one thought, question or command at a time.A quarterly minimum data set (MDS) assessment, dated 3/11/26, indicated Resident B was severely cognitively impaired and was either dependent or required substantial to maximum assistance with all transfers and mobility.A physician's order, discontinued 6/11/26, indicated to utilize a stand lift for transfers.A CNA flow sheet (a sheet which provided a summary of diet, transfers, showers and other information) indicated Resident B transferred with a stand lift.The clinical record indicated Resident B had a shower on 6/8/26 at 4:08 p.m.A comprehensive minimum data set (MDS) assessment, dated 6/10/26, indicated Resident B was severely cognitively impaired and was either dependent or required substantial to maximum assistance with all transfers and mobility.A nursing progress note, dated 6/10/26 at 5:45 p.m., indicated the resident had complained of severe right upper extremity/shoulder pain. The physician and family were notified and an x-ray was ordered.There was no prior progress notes documented to indicate Resident B had suffered an injury, had rolled or fallen out of bed, or was found on the floor.A radiology report, dated 6/11/26 at 7:03 a.m., indicated Resident B had a fracture involving the humeral head and neck with displacement.A nursing progress note, dated 6/11/26 at 9:54 a.m., indicated Resident B had reported to the nurse she had fallen out of bed. She had complaints of pain/discomfort in the right arm. The x-ray revealed a mildly impacted and displaced fracture of the proximal right humerus. Resident B was sent to the hospital with the fracture results and recommendations for a CT (computed tomography) scan.There were no progress notes or documentation to indicate how or who removed Resident B from the floor if she had fallen out of bed since Resident B was dependent or required substantial maximum assistance for mobility.A physician's order, dated 6/11/26 at 10:36 a.m., indicated Resident B could be sent to the emergency room for an evaluation and treatment.A facility fall event, dated 6/11/26 at 9:54 a.m., indicated Resident B reported she rolled from bed. It was unwitnessed. She complained of right shoulder pain.A social service note, dated 6/11/26 at 10:51 a.m., indicated Resident B had pain in her shoulder and stated she fell out of bed and that was why it hurt.A nursing progress note, dated 6/14/26 at 5:53 p.m., indicated Resident B had increased anxiety toward rolling and was afraid she was going to fall.A facility obtained witness statement, dated 6/11/26, indicated CNA 4 reported she cared for Resident B, on 6/8/26, and no fall or event had occurred. She did report transferring Resident B with the assist of two when the resident's legs gave out. She had no knowledge of Resident B rolling out of bed.A facility obtained witness statement, not dated, indicated QMA 6 reported Resident B had complained of pain before her shower. After the shower, at dinner, Resident B complained of more pain. No incidents were reported to QMA 6.A facility obtained witness statement, dated 6/11/26, indicated RN 7 reported Resident B had stated she fell out of bed.A facility obtained witness statement, not dated, indicated CNA 3 reported on 6/8/26 after Resident B's shower, she was transferred with a two (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	person assist. A noise was heard and the CNAs thought Resident B's shirt had ripped. Resident B was placed back in her wheelchair with no complaints.A facility obtained witness statement, dated 6/11/26, indicated LPN 8 reported Resident B had stated she had fallen out of bed but could not recall what day.A facility obtained witness statement, not dated, indicated RN 9 reported on 6/10/26 Resident B complained of right shoulder pain. She obtained an order for an x-ray. She did not witness any incidents.The facility investigation did not contain documentation to indicate how or who removed Resident B from the floor if she had fallen out of bed since Resident B was dependent or required substantial maximum assistance for mobility.During an interview, on 6/29/26 at 2:01 p.m., CNA 3 indicated she completed Resident B's shower on 6/8/26. The resident did not report pain until she was dressed and placed back into her wheelchair. Resident B was to be transferred with a mechanical stand-up lift (a machine which helped the resident stand up), but there was a concern with the lift. CNA 4, who assisted with the transfer, lifted the resident, without using the mechanical lift or a gait belt, while CNA 3 undressed her for the shower. After the shower had been completed, the same transfer method was used again. CNA 4 lifted the resident without any assistive device while CNA 3 dressed the resident. CNA 3 indicated during the transfer, she heard a ripping sound and thought the resident's clothing had ripped, but she did not investigate to see if the clothing had ripped.During an interview, on 6/29/26 at 2:09 p.m., CNA 4 indicated CNA 3 was in Resident B's room trying to get her on the stand-up lift, but Resident B kept putting her feet outside of the flat surface on the lift. There were no safety straps for the legs on the lift. When they got the resident to the shower, CNA 4 decided to stand her up so CNA 3 could undress her. She did not use the lift or a gait belt. She lifted the resident from under her arms and CNA 3 undressed her. CNA 4 indicated she asked CNA 3 to use the call light when the shower was completed, and the resident was ready to transfer back into her wheelchair. When the shower was completed, CNA 4 lifted Resident B without any assistive devices while CNA 3 dressed her and then the resident was transferred into her wheelchair. CNA 4 indicated she did not use the lift because she did not feel it was safe without the leg strap. She indicated she had worked a double (evening and night shift) and Resident B did have complaints of discomfort on the night shift.During an interview, on 6/30/26 at 10:21 a.m., Physical Therapist 5 indicated if a mechanical stand-up lift was not safe, the CNA should inform the nurse and utilize the full body mechanical lift (a lift which had a sling and used to lift the whole body). Resident B had utilized a mechanical stand-up lift for transfers since May of 2023. If a gait belt was used to transfer Resident B, it would most likely require two, maybe even three staff as the resident was a larger person.A current facility policy, titled Policy and Procedure for Mechanical Lift Transfer Usage, undated and received from the Executive Director on 6/30/26 at 11:54 a.m., indicated .All residents determined to require a two-person transfer will be transferred with the use of a Mechanical Lift or a Sit-Stand Lift.This citation relates to Intake 3045109.410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(2)