STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntingburg, The	1712 Leland Dr Huntingburg, IN 47542

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure required resident admission assessments were completed timely for 2 of 4 resident records reviewed. admission assessments were not completed within the first 14 days following admission. (Resident C, Resident D)Findings include:1. During record review on 1/23/26 at 10:00 A.M., Resident C's admission Minimum Data Set (MDS) assessment dated [DATE] was incomplete. Resident C was admitted to the facility on [DATE]. 2. During record review on 1/23/26 at 10:40 A.M., Resident D's admission MDS assessment dated [DATE] was incomplete. Resident D was admitted to the facility on [DATE]. During an interview on 1/23/26 at 11:55 A.M., the MDS nurse indicated she had been busy working on a care plan project and had not gotten to all the due MDS assessments. On 1/23/26 at 2:25 P.M., the Director of Nursing (DON) supplied a facility policy titled, Guidelines for Assessments, dated 5/29/24. The policy included, Policy: It is the policy of the facility to ensure that assessments of the residents take place timely, at the appropriate time and are accurate . admission (Comprehensive) . MDS Completion Date . No Later Than . 14th calendar day of the resident's admission .3.1-31(d)(1)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntingburg, The	1712 Leland Dr Huntingburg, IN 47542

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide necessary treatment and services for 2 of 4 residents reviewed for dementia care. Resident behaviors were not monitored, and the plan of care was not updated following new behaviors, known behaviors were not documented, denture cleaning tablets were left unsecured in a dementia unit, and staff failed to offer redirection. (Resident B, Resident C)Findings include:1. During a review of facility-reported incidents on 1/22/26 at 2:30 P.M., an incident dated 1/15/26 at 6:45 P.M. indicated that Resident B was walking in a common area of the memory care unit when he used his right hand to make contact with the back of the neck of another resident. Both residents have impaired cognition. A facility reported incident dated 1/20/26 at 7:01 A.M., indicated Resident B walked into another resident's room and grabbed her left forearm. During record review on 1/22/26 at 2:40 P.M., Resident B's diagnoses included, but were not limited to, dementia with mood disturbance and major depressive disorder with psychotic symptoms.Resident B's most recent admission Minimum Data Set (MDS), dated [DATE], indicated the resident had severe cognitive impairment and displayed, Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) one - three (1-3) days during a 7 day review period.Resident B's care plan included, but was not limited to, the resident displays behavioral symptoms related to a dementia diagnosis (last revised 11/28/25). Interventions included, but were not limited to, conduct an evaluation of my behavioral symptom(s) to determine what strengths or abilities & needs are communicated via the behavior, and conduct an evaluation of my behavioral symptom(s) to determine what strengths or abilities and needs are communicated via the behavior (initiated 11/28/25).Resident B's nurse's progress notes included, but were not limited to:11/30/25 at 1:18 P.M. - Resident was lunging and swinging at staff and being verbally aggressive. The resident was also cursing at another resident and attempting to grab them. 12/1/25 at 1:19 A.M. - Resident was spontaneously aggressive with a staff member in the unit, yelling at staff, threatening staff, and attempting to hit staff.12/28/25 at 12:22 A.M. - Resident became aggressive with CNA upon redirection.1/20/26 at 8:11 A.M. - Resident went into another resident's room and grabbed the resident by the arm. 1/21/26 9:30 A.M. - Behavior Note - After further investigation by the Director of Nursing (DON), it was reported by CNA that on 1/19/26 resident was found in another resident's room, sitting on her bed with both of his hands around the resident's left wrist, a firm grip. The resident was yelling, We need to get rid of her because she is the devil. Staff attempted redirection without success. They removed his hands from the other resident's left wrist and escorted him from her room. He was unable to describe or remember the incident due to diagnoses. 1/22/26 at 11:06 A.M. - At approximately 11:02 P.M., Resident B was found eating a Polydent tablet. Poison control center contacted. This LPN was informed to watch the resident for the next 2-3 hours for excessive drooling, vomiting, swelling of the mouth or throat, or trouble breathing.Resident B's record contained no documentation regarding the incident dated 1/15/26. During an interview on 1/23/26 at 11:45 A.M., Activity Assistant 4 indicated Resident B's Polydent tablet was left in his room the night prior when the resident was found eating it. LPN 6 indicated denture tablets and other personal hygiene items should not be left in resident rooms on a dementia unit and should be stored away from resident access. During an interview on 1/23/26 at 11:55 A.M., the MDS nurse indicated the resident's plan of care should be updated following a new or increased behavior with a new intervention to help minimize or prevent behavior from recurring. During an interview on 1/23/26 at 2:15 P.M., the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntingburg, The	1712 Leland Dr Huntingburg, IN 47542

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON indicated there was no nursing documentation made in Resident B's record regarding the incident on 1/15/26. 2. During an observation on 1/22/26 at 9:05 P.M., Resident C was observed sitting on the floor in a common area in front of the nurse's station. CNA 9 was observed sitting in a reclining chair in the common area, and CNA 10 was observed standing at the nurse's station. Neither CNA was assisting the resident. The Facility Administrator knelt down next to Resident B to talk with her, and the resident was assisted to a couch in the common area. During an interview on 1/22/26 at 10:15 P.M., CNA 10 indicated Resident C sits herself on the floor at times. During record review on 1/23/26 at 10:00 A.M., Resident C's diagnoses included, but were not limited to Alzheimer's disease, anxiety, and unspecified psychosis. Resident C's care plan included, but was not limited to, the resident presents with an alteration in ability to communicate (initiated 12/23/25), the resident has the potential risk for injury and/orsocial isolation due to decreased visual acuity (initiated: 12/23/2025), with an intervention assess the environment. Make modifications as necessary to make the environment conducive to safety & ongoing interaction. Resident has impaired cognition/function or impaired thought process (initiated 12/23/25) with an intervention to cue, reorient, and supervise as needed. Resident displays behavior symptoms (initiated 12/23/25) with an intervention to intervene when inappropriate behavior is observed and use interventions that address the abilities and needs reflected in the specific symptom or symptoms. Resident C's care plan contained no plan of care regarding the resident's desire to sit on the floor. Resident C's nurse's progress notes contained no documentation of the resident sitting on the floor on 1/22/26 at 10:15 P.M. No observations or assessments were completed following the behavior. During an interview on 1/23/26 at 11:45 A.M., LPN 6 indicated that if a resident is on the floor, the nursing staff should document and assess the resident. During an interview on 1/23/26 at 12:40 P.M., LPN 8 indicated that staff should anticipate Resident C's needs and consider if the resident is displaying a behavior such as sitting herself on the floor, staff may consider why the resident is doing that. The resident may have been tired and needed assistance to bed. On 12/23/26 at 2:25 P.M., the Director of Nursing supplied a facility policy titled, Guidelines for Behavior Management Meetings Psychotropic Medication, dated 8/18/23. The policy included, .Standards: .2. The facility will investigate behaviors in an effort to determine the root cause of the behavior . Nursing . 2) Monitors for presence of target behaviors on a daily basis and documenting same .This citation relates to intake 2714418. 3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntingburg, The	1712 Leland Dr Huntingburg, IN 47542

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and record review, the facility failed to ensure physician prescribed diets were followed for 2 of 4 residents reviewed for dietary services. An order to receive ice cream with meals and an order to receive finger foods was not followed during 1 of 1 mealtimes observed. (Resident B, Resident F)Findings include:1. During an interview on 1/22/26 at 10:30 P.M., LPN 8 indicated the facility had no ice cream for the residents and that the kitchen did not keep ice cream in stock. During record review on 1/23/26 at 10:30 A.M., Resident F's physician orders included, but were not limited to, fortified foods with each meal, ice cream with lunch and dinner (started 12/22/25). During an observation on 1/23/26 at 12:15 P.M., Resident F received her lunch tray in the locked dementia unit. The resident's tray did not include ice cream. During an interview on 1/23/26 at 12:35 P.M., LPN 6 indicated the facility did not keep ice cream in stock unless the staff paid for it out of their own pocket. Residents with orders to receive ice cream do not receive it. 2. During record review on 1/23/26 at 10:00 A.M., Resident B's diagnosis included, but were not limited to, Alzheimer's disease and anorexia. Resident B's physician orders included but were not limited to, fortified foods with each meal, a finger food-focused diet (started 12/29/25). During an observation on 1/23/26 at 12:15 P.M., Resident B received her lunch tray in the locked dementia unit. The resident received the same meal as other residents, which included fish, noodles, cooked vegetables, and a roll. Resident B picked up her fork and poked at some of the items on her plate, but did take a bite.During an interview on 1/23/26 at 12:35 P.M., LPN 6 indicated that the residents with an order for finger foods do not usually get them; they get the same meal as everyone else. During an interview on 1/23/26 at 2:20 P.M., the Director of Nursing (DON) indicated the facility did not have a policy specific to following diet orders, but indicated it was the policy to follow all physician orders. This citation relates to intake 2714418. 3.1-21(b)