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	09/12/2025

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

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure residents received food at safe and appetizing temperatures for 1 of 1 meal trays tested for taste and temperature of food.Finding includes:On 9/8/25 at 10:30 A.M., three residents voiced concerns about the taste, variety, and temperatures of the food at the resident council meeting. On 9/8/25 at 12:30 P.M., a meal tray was obtained to test the taste and temperatures of the food. The hoagie sandwich (hamburger bun, slice of cheese, and piece of ham) felt and tasted cold and tested 107.7 degrees Fahrenheit. The fries were 96.7 degrees Fahrenheit and tasted cold. On 9/12/25 at 10:36 A.M., a current non dated Food Temperatures Policy was provided by the Administrator and indicated, . Hot Foods: Hold at 135 F or greater throughout the service process.3.1-21(a)(2)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to distribute and serve food in accordance with professional standards for 1 of 1 kitchen observed. Food temperature logs were not completed for all meals. Findings include:1. During an observation of the kitchen on 9/7/25 at 11:30 A.M., [NAME] 3 was plating chili mac, Italian vegetable blend, cornbread, and pears for the lunch meal. On 9/7/25 at 12:11 P.M., the Memory Hall cart went out of the kitchen. At that time, the log book for meal temperatures was reviewed and the page was completely blank. [NAME] 3 indicated the food temperature was taken when they got it out of the ovens and put it on the steam table. When the last cart went out, he would take the food temperatures again and that's when they get wrote into the log book. 2. On 9/8/25 at 12:05 P.M., the Dietary Manager was observed plating ham and cheese hoagies, baked french fries, baked beans, and lime gelatin with diced pears for the lunch meal. At that time, the food temperature log was reviewed. The dinner log for 9/7/25 was completely blank. The lunch log for 9/8/25 was written in pencil and not completely filled in. The Regional Director of Operations (RDO) was standing next to the log book with a pencil . At that time, the dietary manager indicated she had taken the temperatures, had them in her head, she had not wrote them in the book, but would write them in the log book later. During an interview on 9/8/25 at 12:27 P.M., the RDO indicated she expected kitchen staff to fill the food temperature log out after the tray line was complete. They should be putting the temperatures on paper and then writing in to the log from there. A copy of the food temperature log was requested at that time. On 9/8/25 at 12:35 P.M., copies of the requested food temperature log were provided by the RDO and the dinner log for 9/7/25 was filled in as well as the rest of the 9/8/25 lunch log. On 9/12/25 at 10:36 A.M., a current, non dated Food Temperature Policy was provided by the Administrator and indicated, . Temperatures of TCS (temperature controlled for safety) foods shall be recorded before being served from the steam table . 3.1-21(i)(2)3.1-21(i)(3)

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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 ensure proper notification following a change of condition for 1 of 3 residents reviewed for falls. (Resident 17)Finding includes:1. On 9/8/25 at 11:05 A.M., Resident 17's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and psychotic disorder. The most recent significant change Minimum Data Set (MDS) assessment, dated 8/13/25, indicated a severe cognitive impairment and no behaviors. Resident 17 required partial to moderate assist (helper does half the effort) with toileting, substantial to maximum assist (helper does more than half the effort) with showers, and supervision or touching assist with eating. A current falls care plan, dated 7/29/25, indicated, but was not limited to, the following interventions: Notify and update MD as needed, dated 7/29/25. On 9/2/25 at 5:36 P.M., a nursing note indicated Resident 17 fell while coming through the doorway of the dining room. The resident hit their head with an open abrasion noted. The resident also had an abrasion to the nose and skin tear to the left hand. On 9/5/25 at 1:09 P.M., a nurses note indicated Resident 17 was very lethargic and more confused than usual. The resident was attempting to drink food and needed assistance with lunch (out of the norm for resident). The resident exhibited speech that was hard to comprehend. No parties were notified of the resident's change of condition at that time. Twenty six hours after the initial change of condition, a nurses note dated 9/6/25 at 3:00 P.M. indicated resident was lethargic and restless, unable to walk or get up without assistance. The resident was hard to awake, and had slurred speech. Resident 17 was then sent to the emergency room (ER) for evaluation and treatment. On 9/11/25 at 11:33 A.M., the Director of Nursing (DON) indicated staff had not notified Resident 17's physician after the change of condition on 9/5/25 due to trying to keep the residents in-house and treat at the facility instead of sending out. She indicated the following day (9/6/25), the resident seemed worse, so that was when the notification was made. On 9/12/25 at 11:34 A.M., the Administrator provided a current non-dated Registered Nurse (RN) job description that indicated Role Responsibilities - Nursing Care . Notifies the resident's attending physician and next-of-kin when there is a change in the resident's condition 3.1-5(a)(2)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure accuracy of assessments for 3 of 21 residents reviewed for assessments. Minimum Data Set (MDS) assessments did not accurately reflect medications the residents were taking. (Resident 13, Resident 2, Resident 6)Findings include:1. On 9/11/25 at 10:33 A.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, diabetes mellitus, and hypertension. The most recent significant change MDS assessment, dated 8/8/25, indicated a severe cognitive impairment. The MDS indicated Resident 13 used an anticoagulant medication, and indicated an antiplatelet medication had not been used. Physician orders included, but were not limited to:Aspirin Tablet Chewable (an antiplatelet) 81mg (milligram) every night for hypertension, dated 8/3/25 and discontinued 8/15/25. The clinical record lacked an order for an anticoagulant medication. Resident 13's Medication Administration Record (MAR) for August 2025 indicated he had taken Aspirin during the 8/8/25 MDS look back period. The MAR lacked documentation that an anticoagulant had been administered. 2. On 9/11/25 at 8:54 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, dementia, anxiety, and depression. The most recent significant change MDS assessment, dated 8/11/25, indicated a severe cognitive impairment. The MDS indicated use of an antipsychotic medication, and indicated an anticonvulsant medication had not been used. Current physician orders included, but were not limited to:Gabapentin Capsule (an anticonvulsant) 300mg by mouth with meals, dated 7/23/25. The clinical record lacked an order for an antipsychotic medication. Resident 2's MAR for August 2025 indicated he had taken Gabapentin during the 8/11/25 MDS look back period. The MAR lacked documentation that an antipsychotic had been administered. 3. On 9/8/25 at 11:43 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and psychotic disorder. The most recent significant change MDS assessment, dated 8/15/25, indicated a severe cognitive impairment. The MDS indicated an antidepressant had not been used. Current physician orders included, but were not limited to:Mirtazapine Oral Tablet (an antidepressant) 7.5mg in the evening, dated 6/28/25. Resident 6's MAR for August 2025 indicated he had taken Mirtazapine during the 8/11/25 MDS look back period. On 9/11/25 at 2:16 P.M., the MDS Coordinator indicated the medications for the most recent MDS assessments for Resident 13, Resident 2, and Resident 6 were entered in error. At that time, she indicated in lieu of a policy, the facility used the RAI (resident assessment indicator) manual for completion of the MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure implementation of care plan interventions for 2 of 3 residents reviewed for falls. A call light was observed out of reach, nonslip material was not placed under furniture, and a resident was not taken to the common area or toileted after a meal as indicated in risk for falls care plans. (Resident 6, Resident 35)Findings include:1. On 9/8/25 at 11:46 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, renal failure, dementia, anxiety, and psychotic disorder. The most recent significant change Minimum Data Set (MDS) assessment, dated 8/15/25, indicated a severe cognitive impairment and no behaviors. Resident 6 required substantial to maximum assist (helper does more than half the effort) with eating, toileting, bed mobility, showers and transfers. Resident 6 had one fall with no injury. A current risk for falls care plan, initiated 6/15/21 and last revised 5/22/25, included, but was not limited to, the following interventions:Resident to be brought to common area after meals, dated 8/30/25.Resident to be toileted before and after meals, dated 7/10/25.On 9/9/25 at 12:15 P.M., Resident 6 was observed sitting in the dining room eating lunch. At 12:34 P.M., CNA 21 removed the plate in front of the resident and put it away. Resident 6 sat at the dining room table until 1:17 P.M. (43 minutes from the end of the meal) when CNA 21 and CNA 9 came and got the resident and wheeled in the wheelchair to his room. The resident was then transferred from the wheelchair to the bed at which time the resident's brief was checked. At that time, CNA 21 indicated they did not currently offer toileting for Resident 6 as he was incontinent. 2. On 9/8/25 at 11:46 A.M., Resident 35's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, depression, and psychotic disorder. The most recent significant change MDS assessment, dated 8/7/25, indicated a severe cognitive impairment and no behaviors. Resident 35 required partial to moderate assist (helper does less than half the effort) with toileting and showers, and supervision or touching assist with bed mobility and transfers. Resident 35 had one fall with no injury. A current risk for falls care plan, dated 12/20/22 and last revised 11/18/24, included, but was not limited to, the following interventions: Dycem (a nonslip material) under dining room table legs in common areas, dated 5/14/25. Keep call light in reach, revised 10/5/24. On 9/9/25 at 9:00 A.M., Resident 35 was observed sitting in a recliner in her room with the foot rest up. The resident had shoes on. A call light was observed coiled up and sitting on the floor well out of reach of the resident. At that time, the furniture in the dining room and common area were observed without dycem under the legs. On 9/12/25 at 11:34 A.M., the Administrator provided a current Comprehensive Care Plan policy, last revised 3/23/21, that indicated The Comprehensive Care Plan will further expand on the resident's risks, goals and interventions using the Person-Centered Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs . discuss and develop quantifiable objectives along with appropriate interventions in an effort to achieve the highest level of functioning and the greatest degree of comfort/safety and overall well-being attainable for the resident 3.1-35(b)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise care plans with new interventions to prevent falls for 3 of 3 residents reviewed for falls. (Resident 17, Resident 6, Resident 35)Findings include:1. On 9/8/25 at 11:05 A.M., Resident 17's clinical record was reviewed. Resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, dementia and psychotic disorder. The most recent significant change Minimum Data Set (MDS) assessment, dated 8/13/25, indicated a severe cognitive impairment and no behaviors. Resident 17 required partial to moderate assist (helper does half the effort) with toileting, and substantial to maximum assist (helper does more than half the effort) with showers. The MDS assessment indicated one fall since the prior assessment on 7/29/25 with no major injury. A current falls care plan, dated 7/29/25, indicated the following interventions: Attempt to keep areas free of clutter, dated 7/29/25. Keep call light in reach, dated 7/29/25. Notify and update MD as needed, dated 7/29/25. Therapy screen as indicated, quarterly and as needed, dated 7/29/25. Hourly rounding, dated 8/22/25. Non skid strips to left side of bed under fall mat, dated 8/22/25. Tennis balls are properly positioned and in place on walker legs, dated 8/29/25. Make sure gripper socks stay in place to prevent falls, dated 8/29/25. Fall mat to open side of bed on top of non skid strips., dated 8/30/25. Offer toileting to resident when doing rounding on unit, dated 8/30/25. Social Services to have family get nonskid shoes for resident, dated 9/2/25. Resident 17's clinical record included, but was not limited to, the following falls: Fall 1On 8/3/25 at 10:34 A.M., a nursing progress note indicated the resident fell when they lost balance when walking with walker out the dining room door. The clinical record lacked a new intervention to the falls care plan following the fall. Fall 2On 8/8/25 at 6:30 A.M., a nurses note indicated the resident was found sitting on buttocks beside the bed in resident's room. The note indicated staff to encourage resident to wear gripper socks as fall prevention. The intervention was not added to the care plan for 21 days (8/29/25). Fall 3On 8/30/25 at 1:30 A.M., a general note indicated resident was found in room next to the bed lying on the left side. Resident 17 had a red bruise to the left forearm. The floor was noted to bed wet and two grip strips placed next to resident's bed. The clinical record lacked the new intervention to the falls care plan following the fall. Fall 4On 8/30/25 at 11:30 P.M., a general note indicated resident was found on the left side on the floor in front of the bed. A pressure reduction concave mattress was applied to the bed. The clinical record lacked the new intervention to the falls care plan following the fall.2. On 9/8/25 at 11:46 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, renal failure, dementia, anxiety, and psychotic disorder. The most recent significant change Minimum Data Set (MDS) assessment, dated 8/15/25, indicated a severe cognitive impairment and no behaviors. Resident 6 required substantial to maximum assist (helper does more than half the effort) with eating, toileting, bed mobility, showers and transfers. Resident 6 had one fall with no injury. A current risk for falls care plan, initiated 6/15/21 and last revised 5/22/25, indicated the following interventions:Attempt to keep areas free of clutter, dated 6/15/21.Keep call light in reach, dated 6/15/21.Therapy screen as indicated, quarterly and as needed, dated 6/15/21.Encourage to use enabler bars when getting out of bed for stabilization, dated 10/7/21.Keep bed in lowest position, dated 9/22/22.Offer toileting every two hours, dated 5/21/23.Dycem to cushion, dated 12/22/23.Anti-roll backs to wheelchair, dated 6/24/24.Keep all frequently used items within reach, dated 10/5/24.Non-skid socks while in bed, dated 5/22/25.Resident to be toileted before and after meals, dated 7/10/25.Resident to be brought to common area after meals, dated 8/30/25.Resident 6's clinical record included, but was not limited to, the following falls:Fall 1A nurses note, dated 6/5/25 at 12:50 A.M., indicated resident was found lying on the floor next to the bed during bed checks. The immediate intervention noted was a low bed. The clinical record lacked a new intervention to the falls care plan following the fall. Fall 2A nurses note, dated 8/11/25 at 1:56 A.M., indicated resident was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	found sitting on the floor next to roommates bed. A skin tear was noted to the left elbow. The note indicated resident to be encouraged to wear gripper socks when in bed as a fall prevention intervention. At that time, the care plan already had in place an intervention to wear gripper socks in bed, dated 5/22/25. The clinical record lacked a new intervention to the falls care plan following the fall. 3. On 9/8/25 at 11:46 A.M., Resident 35's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, depression, and psychotic disorder. The most recent significant change MDS assessment, dated 8/7/25, indicated a severe cognitive impairment and no behaviors. Resident 35 required partial to moderate assist (helper does less than half the effort) with toileting and showers, and supervision or touching assist with bed mobility and transfers. Resident 35 had one fall with no injury. A current risk for falls care plan, dated 12/20/22 and last revised 11/18/24, indicated the following interventions: Keep call light in reach, revised 10/5/24. Notify and update MD as needed, revised 10/5/24. Attempt to keep areas free of clutter, revised 10/5/24. Therapy screen as indicated, quarterly and as needed, revised 10/5/24. Therapy evaluation, dated 12/2/24. Pain medication evaluation, revised 12/31/24. Encourage to use walker with ambulation, dated 3/17/25. Dycem under dining room table legs in common areas, dated 5/14/25. Resident 35's clinical record included, but was not limited to, the following falls: Fall 1A nurses note, dated 6/11/25 at 5:10 P.M., indicated resident was found scooting on the floor towards the doorway in another resident's room. The clinical record lacked an updated care plan intervention following the fall. Fall 2A nurses note, dated 8/7/25 at 10:56 P.M., indicated resident was found sitting on buttocks on the floor near her bed. The note indicated staff to ensure resident wearing gripper socks when not wearing shoes as an immediate fall prevention intervention. The clinical record lacked the new intervention to the falls care plan following the fall. On 9/11/25 at 11:35 A.M., the Director of Nursing (DON) indicated when a resident experienced a fall, an IDT meeting should be held the following morning, or if on a weekend the following Monday. Any new falls interventions discussed should then be placed into the resident's care plan that same day. On 9/12/25 at 10:32 A.M., the Administrator provided a current Incident/Accident/Falls policy, last revised 4/5/22, that indicated . Each fall needs a new care plan intervention rolled out 3.1-35(d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure physicians orders were followed for insulin administration and blood glucose monitoring (blood sugar testing) for 1 of 9 residents randomly observed during medication administration. Resident 2 was observed to receive the wrong dose of insulin and Resident 2 and Resident 8's medications were left blank on the Medication Administration Record (MAR). (Resident 8, Resident 2)Findings include:1. On 9/8/25 at 11:40 A.M., Registered Nurse 16 was observed administering insulin to Resident 2. His blood sugar was 537. She indicated for a blood sugar (BS) of 501-600, the resident should get 9.5 units. After obtaining the resident's Humalog insulin pen, she applied the needle, primed the pen with two units of insulin, used anti-bacterial hand rub (ABHR), and put on her gloves. Once she entered the resident's room, she dialed the pen to 9.0 units and administered the dose into the resident's abdomen. At that time, she indicated you can't give 9.5 units because the pen only allows one unit increments. The nurse did not call the physician for clarification of the order before administering the wrong dose of insulin to the resident. On 9/8/25 at 2:30 P.M., Resident 2's record was reviewed. Diagnoses included, but were not limited to, dementia and diabetes mellitus type II. Current Physician's orders included, but were not limited to, the following: Humalog Insulin Solution 100 units/milliter (mL) Inject as per sliding scale: if blood sugar (BS) 130-150 = 1 unit; 151-200 = 2 units; 201-250 = 3 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 7.5 units; 401-500 = 8.5 units; 501-600 = 9.5 units; 601+ = 10.5 units subcutaneously three times a day for diabetes mellitus type II. Physician notification for BS greater than 400 or less than 70, ordered 1/7/25 A current Diabetes Care Plan, last reviewed 10/21/24, included an intervention to administer antidiabetic medications per order. The Medication Administration Record (MAR) for September 2025 indicated the resident received 9.5 units of Humalog insulin for his noon dose on 9/8/25. On 9/12/25 at 9:48 A.M., RN 16 indicated they should give medications as ordered and call for clarification if there is confusion. She indicated the dose of insulin was not able to be put into the MAR manually and since 9.5 units was the dose that should have been given as ordered on the sliding scale, that was the dosage that was entered even though she only gave 9.0 units. At that time, she indicated she was going to call the MD and get clarification of the sliding scale order. She indicated the dose given should be documented in the MAR. 2. On 9/9/25 at 10:58 A.M., Resident 8's clinical record was reviewed. Diagnosis included, but were not limited to, diabetes mellitus. The most recent significant change Minimum Data Set (MDS) assessment, dated 6/20/25 indicated Resident 8's cognitive status was unable to be determined, and she received insulin on 7 of 7 days during the look back window. Current Physician's Orders included, but were not limited to, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lantus (insulin).100 UNIT/ML (mililiter) Solution pen-injector. Inject 5 unit subcutaneously in the morning. dated, 5/15/25 Insulin Lispro 100 UNIT/ML Solution. Inject 6 unit subcutaneously four times a day. dated, 5/16/25 Current care plans included, but were not limited to, diabetes with current interventions to check blood sugars and administer medications per order, initiated 7/1/25. The facility failed to check Resident 8's blood sugar and administer the dose of insulin on the following dates and times during a 3 month look back period: June: 6-- insulin lispro 100unit/ml--6:00 PM blood sugar and dose given 14-- insulin lispro 100 unit/ml-- 6:00 PM blood sugar and dose given 19--insulin lispro 100 unit/ml-- 6:00 PM blood sugar and dose given 20-- insulin lispro 100 unit/ml--6:00 AM blood sugar and dose given 20-- Lantus 100unit/ml-- 6:00 AM blood sugar and dose given July: 2-- insulin lispro 100 unit/ml-- 6:00 AM blood sugar and dose given 14-- insulin lispro 100 unit/ml-- 6:00 PM blood sugar and dose given 29-- insulin lispro 100 unit/ml-- 6:00 PM blood sugar and dose given August: 9-- insulin lispro 100 unit/ml-- 12:00 PM blood sugar and dose given 9--insulin lispro 100 unit/ml-- 6:00 PM blood sugar and dose given 13-- insulin lispro 100 unit/ml-- 12:00 AM blood sugar and dose given 3. On 9/11/25 at 8:54 A.M., Resident 2's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus. The most recent significant change Minimum Data Set (MDS) assessment, dated 8/11/25, indicated a severe cognitive impairment and no behaviors. Resident 2 had seven days of insulin injections. Current physician orders included, but were not limited to: Humalog injection solution 100 unit/mL (milliliter) inject as per sliding scale, dated 1/7/25. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Blood glucose monitoring, check and record four times a day for diabetes mellitus, hold insulin if glucose is less than 80, dated 10/30/23. A current diabetes care plan, initiated 10/17/23 and revised 10/21/24, indicated to administer diabetic medications as ordered. Resident 2's Medication Administration Record (MAR) for July, August, and September 2025 indicated the following days that blood glucose monitoring was not completed, and Humalog was not given: 7/29/25 at 4:00 P.M. (MAR left blank) 8/24/25 at 4:00 P.M. (MAR left blank) 9/5/25 at 12:00 P.M. (MAR left blank) On 9/12/25 at 9:00 A.M., the Director of Nursing (DON) indicated she had been unable to find documentation about why resident's insulin had not been documented. At that time, the Regional Clinical Support indicated if a medication is refused or not given for any other reason, there are codes to indicate why it was not given in the resident's MAR and should have been entered. On 9/12/25 at 11:34 A.M., the Administrator provided a current Insulin Administration policy, dated 3/2023, that indicated Document administration and site on the Medication Administration Record . Monitor blood glucose as ordered and document the results per facility policy On 9/12/25 at 11:34 A.M., the Administrator provided a current Physician Orders policy, dated 6/18/23, that indicated All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received On 9/12/25 at 10:36 A.M., a current Following Physician's Orders Policy, dated 6/18/23, was provided by the Administrator and indicated, It is the policy of the facility to follow the orders of the physician . 3.1-35(g)(1)

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	09/12/2025

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff provided a sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents observed for incontinence care and 4 of 9 residents observed during medication passes. Multiple items were touched with gloved hands and the same gloves were used to perform care, hand hygiene was not done between dirty to clean tasks, a resident was left with a brown substance on his bottom, staff washed hands with less then 15 second lather, and staff did not sanitize hands between residents during medication passes. (Resident 5, Resident 14, Resident 33, Resident 36, Resident 27)Findings include: 1.On 9/7/25 at 11:02 A.M., Licensed Practical Nurse (LPN) 22 was observed prepping medications for Resident 14 and did not sanitize hands before or after the medication pass. On 9/7/25 at 11:10 A.M., LPN 22 was observed prepping medications for Resident 33 and washed hands with a seven second lather after administering the medications. On 9/7/25 at 11:21 A.M., Registered Nurse (RN) 16 was observed prepping medications for Resident 26 and did not sanitize hands before or after the medication pass. On 9/8/25 at 8:53 A.M., Qualified Medication Aide (QMA 35) was observed prepping medications for Resident 27 and did not sanitize hands before or after the medication pass. 2. On 9/9/25 at 9:43 A.M., Certified Nurse Aide (CNA) 11 was observed to perform incontinence care for Resident 5. CNA 11 used gloved hands to raise the head of the bed using a remote, moved the call light, opened a drawer to remove wipes, then removed Resident 5's blankets. CNA 5 then failed to change gloves and perform hand hygiene before she unfasted the brief, wiped the resident's perineal area, walked to the other side of the room and carried a trashcan with her right gloved hand, and wiped with 2 wipes on the perineal area with the same hand. She then failed to change gloves and perform hand hygiene prior to obtaining a clean brief. Resident 5 rolled to the right side, and CNA 11 used 3 wipes to wipe a bowel movement off. After the 3rd wipe, the wipe was still observed to be brown and Resident 5's buttocks still had a brown substance on it. CNA 11 had then ran out of wipes, threw the empty wipe package in the trashcan, and failed to obtain another package of wipes. She then removed her left glove, tucked the clean brief under Resident 5 with her right gloved hand, fastened the brief, and then removed the right glove, failed to perform hand hygiene before she pulled up Resident 5's blankets, then used the remote to lower the bed. During an interview on 9/11/25 at 1:43 P.M., the Infection Preventionist indicated staff should wash hands using a 20 second scrub/lather time and nursing should sanitize their hands between each resident during medication passes. She further indicated for incontinence care, staff should perform hand hygiene and change gloves after items are touched and prior to incontinence care as well as between dirty and clean. At that time, she indicated staff should hit the call light and request more wipes or remove gloves, perform hand hygiene, and leave the room to obtain more wipes if the resident was not fully cleaned up. On 9/12/25 at 10:36 A.M., a current Handwashing Policy, dated 7/7/23, was provided by the Administrator and indicated . Vigorously scrub hands and arms for 10-15 seconds. Clean under fingernails and between fingers . The whole process should take at least 20 seconds – the time it takes to sing the Happy Birthday song twice . (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	09/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/25 at 10:32 A.M., a current Guidelines for Incontinence Care policy, dated 9/21/23, indicated, .4. Perform hand hygiene 5. Apply latex free non-sterile gloves.7. Assist resident to side lying position by turning towards caregiver .8. If feces present, remove with toilet paper or disposable wipe by wiping from front of perineum toward rectum. Discard soiled materials and gloves. 9. Perform hand hygiene. 3.1-18(b)3.1-18(l)

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to post up-to-date nurse staffing information on the posted nurse staffing form for 6 of 6 days reviewed for posted nurse staffing. The posted nurse staffing form did not have specific hours listed for the nursing staff. (9/7/25, 9/8/25, 9/9/25, 9/10/25, 9/11/25, 9/12/25)Findings include: On 9/7/25 at 8:50 A.M., the posted nurse staffing form was observed by the nurse's station, dated 9/6/25, with a census of 40 residents listed. There was no nursing staff listed on the evening shift from 2:00 P.M.-10:00 P.M. The day shift (6:00 A.M.-2:00 P.M.) included 1 Registered Nurse (RN) for 11.5 hours, 1 Licensed Practical Nurse (LPN) for 8.5 hours, 3 Certified Nurse Aides (CNAs) for 34.5 hours, and 1 Qualified Medication Aide (QMA) for 11.5 hours. The night shift (10:00 P.M.-6:00 A.M.) included 1 RN for 11.5 hours, 1 LPN for 11.5 hours, and 2.5 CNAs for 34.5 hours. On 9/8/25 at 8:00 A.M., the posted nurse staffing form was observed. There was no nursing staff listed on the evening shift from 2:00 P.M.-10:00 P.M. The day shift (6:00 A.M.-2:00 P.M.) included 1 RN for 11.5 hours, 1 Licensed Practical Nurse (LPN) for 8.5 hours, 3 CNAs for 34.5 hours and 1 Qualified Medication Aide (QMA) for 11.5 hours. The night shift (10:00 P.M.-6:00 A.M.) included 1 RN for 11.5 hours, 1 LPN for 11.5 hours, and 2.5 CNAs for 34.5 hours. On 9/9/25 at 9:15 A.M., the posted nurse staffing form was observed. There was no nursing staff listed on the evening shift from 2:00 P.M.-10:00 P.M. The day shift (6:00 A.M.-2:00 P.M.) included 2 LPNs for 23 hours, 3 CNAs for 35 hours and 1 QMA for 12 hours. The night shift (10:00 P.M.-6:00 A.M.) included 1 RN for 12 hours, 1 LPN for 12 hours, 2.5 CNAs for 34.5 hours, and 1 QMA for 12 hours. On 9/10/25 at 8:30 A.M., the posted nurse staffing form was observed. There was no nursing staff listed on the evening shift from 2:00 P.M.-10:00 P.M. The day shift (6:00 A.M.-2:00 P.M.) included 3 LPNs for 36 hours and 3.5 CNAs for 44 hours. The night shift (10:00 P.M.-6:00 A.M.) included 1 RN for 12 hours, 2.5 CNAs for 28 hours and 1 QMA for 12 hours. On 9/11/25 at 9:00 A.M., the posted nurse staffing form was observed. There was no nursing staff listed on the evening shift from 2:00 P.M.-10:00 P.M. The day shift (6:00 A.M.-2:00 P.M.) included 1 RN for 12 hours, 1 LPN for 12 hours, and 3 CNAs for 40 hours. The night shift (10:00 P.M.-6:00 A.M.) included 1 RN for 12 hours, 1 LPN for 12 hours, and 3 CNAs for 36 hours. On 9/12/25 at 8:15 A.M., the posted nurse staffing form was observed. There was no nursing staff listed on the evening shift from 2:00 P.M.-10:00 P.M. The day shift (6:00 A.M.-2:00 P.M.) included 1 RN for 12 hours, 3 CNAs for 36 hours, and 2 QMAs for 24 hours. The night shift (10:00 P.M.-6:00 A.M.) included 1 RN for 12 hours, 1 LPN for 12 hours, and 3 CNAs for 36 hours. The posted nurse staffing forms lacked specific hours worked for nursing staff. During an interview on 9/8/25 at 8:00 A.M., LPN 22 indicated she came in at 7:00 A.M., was the only nurse on the floor at that time (covering for the memory unit as well as working out front), and would leave at 1:00 P.M. The night nurse left at 7:00 A.M. and RN 16 would not come in until 11:00 A.M. There was 1 QMA working on the floor at that time. During an interview on 9/12/25 at 10:46 A.M., Regional Clinical Support indicated they don't update the posted nurse staffing forms for accuracy until the next day. She was unaware it needed to be in real time while posted. On 9/12/25 at 10:36 A.M., a current, non dated Posted Nurse Staffing Policy was provided by the Administrator and indicated, It is the policy of the facility, in cooperation with Medicare/Medicaid Services, (CMS), to comply with the requirement of daily posting of nursing staff in the facility . must post daily, at the beginning of each shift, the facility specific shift schedule for the 24 hour period, the number and category of nursing staff employed or contracted by the facility for each 24 hour period, as well as the total number of hours worked by licensed and licensed nursing staff who are directly responsible for resident care . Data must be updated as changes arise-Example-a call in that changes the staffing number reported on the BIPA [sic] form . Note: CMS does not require that the daily census (calculated at midnight the previous night), be posted as part of this [BIPA] Rule .