STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155233	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Batesville, The	958 E Hwy 46 Batesville, IN 47006

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 store and prepare foods under sanitary conditions for 3 of 3 kitchen observations and label residents' food items appropriately in the Resident Snack Refrigerator for 1 of 1 Resident Snack Refrigerators. Findings include:1.During the initial kitchen observation, on 03/15/2026 at 9:25 A.M., [NAME] 4 was identified as the staff member in charge. The [NAME] did not know if the dishwasher was a high temperature sanitizing dishwasher or a chemical sanitizing dishwasher. The [NAME] indicated they had worked at the facility for only a few weeks. During the observation of the kitchen with Dietary Aide (DA) 6, on 03/15/2026 at 9:26: A.M., the DA indicated she had worked at the facility since October. The following was observed: -A silver cart on wheels, containing a stack of clean meal trays, was littered with brown crumbs and white/gray splatters,-The area around the steam table reservoirs was littered with brown crumbs,-The plate warmer was littered with brown crumbs on the inside around the top edge and at the bottom of the warmer,-The plate warmer had gray streaks running down the sides on the inside next to the plates,-In the dry storage room was observed with DA 6. During an interview, at that time, DA 6 indicated the facility dented can policy was for staff to use them first, but she was unsure,-A clean dish rack containing empty trays was littered with brown crumbs and dark brown/black grit on the rails the trays sat on,-A plastic bin of flour sitting on the floor under a window air conditioner had black grit littered across the top, and-A 25-pound bag of sugar lying on the top of the flour bin was littered with black grit. The kitchen cleaning schedules were posted in the kitchen, and all cleaning duties had been initialed as completed for 03/15/2026. Lunch was to begin being served at 10:50 A.M., both [NAME] 4 and DA 6 indicated they were unaware of the need to check the temperature of the foods on the steam table prior to serving the meal. They indicated they were the only ones working on the weekend. 2. A kitchen tour was conducted on 03/16/2026 at 10:58 A.M., with the Dietary Manager (DM). The steam table temperatures were obtained. The lunch meal was chicken ala king over a piece of toast, broccoli, and mashed potatoes for residents on a pureed diet. The pureed broccoli and the mechanical soft (ground) chicken did not come up to an acceptable temperature, and the staff placed the metal steam table containers on the gas stove to heat them up. During the process of obtaining the steam table temperatures, the DM, while wearing gloves, pulled his pants up several times while using and cleaning the thermometer. The following was observed in the kitchen, on 3/16/2026 after the 10:58 A.M. food temperatures were obtained: -Two sheet cake pans full of bowls with lids. The pans were labeled as Dessert for lunch 03/16/2026. The pans had a black residue caked all around the edges of the pans, -A silver cart on wheels, containing a stack of clean meal trays, was littered with brown crumbs and white/gray splatters,-The plate warmer was littered with brown crumbs around the top and on the bottom of the plate warmer, and-Gray streaks were running down the inside of the plate warmer next to the plates. During an interview, on 03/19/2026 at 10:15 A.M., the Regional Dietary Manager indicated [NAME] 4 and DA 6 were the kitchen staff for breakfast and lunch, and they worked every other weekend. The kitchen had a cleaning schedule for the dietary staff to sign when duties were completed. During an interview, on 03/19/2026 10:56 AM., the Regional Dietary Manager indicated she did not think the kitchen staff (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	performed chemical testing on the dishwasher because the company who supplied the chemicals for the dishwasher managed the dishwasher chemicals. 3.During an observation of the kitchen, on 03/19/2026 at 12:49 P.M., the dishwasher wash cycle ran at 160 degrees, the rinse cycle ran at 160 degrees. During an interview, at that time, the DM indicated the dishwasher was a chemical dishwasher, then he changed his mind and said it was a high temperature dishwasher. The dishwasher ran one wash cycle and one rinse cycle. During an interview, on 03/19/2026 at 1:09 P.M., the DM indicated the dishwasher was a high temperature dishwasher and the rinse temperature should reach 180 degrees Fahrenheit or higher. They had not had any foodborne illness recently in the facility and he would be using disposable dishware until the dishwasher was reaching the appropriate temperature levels. The Dishmachine Temperature Log (High Temp) records for January, February, and March 2026, were provided by the Regional Dietary Manager. The records indicated the dishwasher rinse temperature failed to reach the recommended 180 degrees Fahrenheit for the rinse cycle on the following dates in February: -On 02/01/2026, at Breakfast, Lunch, and Dinner, the rinse temperatures were 160 degrees Fahrenheit,-On 02/02/2026, at Dinner, the rinse temperature was 170 degrees Fahrenheit,-On 02/03/2026, at Dinner, the rinse temperature was 160 degrees Fahrenheit,-On 02/04/2026, at Dinner, the rinse temperature was 160 degrees Fahrenheit, and-On 02/05/2026, at Dinner, the rinse temperature was 170 degrees Fahrenheit. The records indicated the Final Rinse temperature should be between 180 to 195 degrees Fahrenheit. Staff were to circle the temperatures that did not meet the minimum standard and notify the supervisor. No temperatures were circled on the records. The current Food Temperatures at Point of Service policy, with a reviewed date of 07/14/2023, indicated, .Hot foods will be held at temperatures 135 degrees or above . 4.The Resident Snack Refrigerator was observed on 03/19/2026 at 2:05 P.M., with Qualified Medication Aide (QMA) 2, and contained the following: -A bottom drawer contained a brown grocery bag, dated 03/18/2026. Inside the bag was an opened plastic bag of salad mix and two bottles of salad dressing. No resident name or room number was noted on any of the products. The QMA indicated items should be labeled with a resident's name and a date. The current Food from Outside Sources policy, dated 07/25/2023, indicated, .Food from outside sources must be labeled with the resident's name, dated, sealed properly and stored appropriately for the type of food . 410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3)

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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 interview, observation, and record review, the facility failed to ensure residents' food was palatable, attractive, and served at the proper temperature for 2 of 3 meal observations. Findings include:1.During an interview with kitchen staff, on 03/15/2026 at 9:25 A.M., [NAME] 4 indicated lunch was to be served starting at 10:50 A.M. Both [NAME] 4 and Dietary Aide (DA) 6 indicated they were unaware of needing to check the temperature of the foods on the steam table prior to serving the meal. They indicated they were the only ones working on the weekend. During an interview, on 03/16/2026 at 10:49 A.M., Resident 46 indicated the food in the facility was not appealing. He usually ate in his room, and his meal was usually cold when he received it. During an interview, on 03/16/2026 at 11:00 A.M., Resident 32 indicated the food was bad. It was always cold. Staff would warm it up, but she shouldn't have to ask them too. She always ate meals in her room. 2. During the survey from 03/15/2026 through 03/19/2026, an anonymous family interview indicated the food served to the residents was a disaster. During an interview, on 03/15/2026 at 12:10 P.M., Resident 48 indicated the food in the facility was not always good and sometimes cold when it was delivered to her room. Her family member would bring her food from home. On 03/16/2026 at 2:12 P.M., Resident 48 indicated her family member had brought her food from home. There were times when food from the kitchen was cold. During an interview, on 03/18/2026 at 1:36 P.M., Resident 23 indicated there was a lot of concerns about the food all the time. The food was cold a lot and it was not appealing. During an observation, on 03/16/2026 at 10:54 A.M., a test tray was sampled. The tray held a slice of toasted bread with cooked chicken, and broccoli. The bread and chicken were covered with gravy, peas, and carrots. There were bowls of mashed potatoes, puree broccoli, puree chicken, and mechanical soft chicken. The food was cold to taste, bland with no flavor, carrots were hard, and hard and tough to chew the non-pureed food. A kitchen tour was conducted on 03/16/2026 at 10:58 A.M., with the Dietary Manager (DM). The steam table temperatures were obtained. The lunch meal was chicken ala king over a piece of toast, broccoli, and mashed potatoes for residents on a pureed diet. The pureed broccoli and the mechanical soft (ground) chicken did not come up to an acceptable temperature, and the staff placed the metal steam table containers on the gas stove to heat them up. On 03/19/2026 a test tray was obtained from the last hall cart. The cart was taken to the hallway from the kitchen at 11:16 A.M. The test tray was brought to the conference room at 11:23 A.M. and the temperature was tested at 11:24 A.M., by the Regional Dietary Manager. The following was observed: -Regular spinach was 113 degrees Fahrenheit, -Pureed spinach was 110 degrees Fahrenheit, and-Pureed ham and beans was 110 degrees Fahrenheit. During an interview, on 03/19/2026 at 11:24 A.M., the Regional Dietary Manager indicated the food on the steam table should not be served at those temperatures below 135 degrees Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The current facility policy titled, Food Temperatures at Point of Service with a revision date of 06/27/2023, was provided by the Regional Dietary Manager on 03/19/2026 at 3:08 P.M. The policy indicated, .Food will be prepared, held, and served in a manner that preserves nutritive value and palatability.Best efforts will be made to present hot food hot and cold foods cold at point of service.Food service staff will monitor palatability of food at point of service by periodic test tray evaluation and review of resident council concerns. 410 IAC (Indiana Administrative Code) 16.2-3.1-21(a)(2)

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview, observation, and record review, the facility failed to answer call lights in a dignified manner for 1 of 14 residents reviewed for dignity. (Resident D)Findings include:During an anonymous resident interview, during the survey from 03/15/2026 through 03/19/2026, the resident indicated staff didn't always answer the call light in a timely manner. Sometimes it took an hour for them to come. During a continuous observation, on 03/17/2026 from 2:27 P.M. through 2:43 P.M., the following was observed:-At 2:27 P.M., Resident D was in his room, the resident's call light was on and visible from the hallway, RN 9 left a resident's room a few doors down from Resident 3's room and went to the nurse's station, sat down at the computer, and started typing, -At 2:30 P.M., Resident D's call light was still on, unanswered, a (Certified Nurse Aide) CNA from another hallway, went to a closed room, retrieved a full body mechanical lift, and stopped at the nurses' station and asked RN 9 for assistance. The RN left the nurses' station to assist the CNA,-At 2:34 P.M., Resident D's call light remained on without staff present, -At 2:38 P.M., Resident D's call light remained on without staff present, -At 2:41 P.M., Resident D's call light remained on, RN 9 returned to the nurse's station and sat down in front of the computer. Another nurse came to a medication cart at the nurses' station and was working on the computer, -At 2:43 P.M., Resident D's light remained on, RN 9 got up from the desk and went to the Assistant Director of Nursing's office,-At 2:43 P.M., Resident D's call light was answered by a CNA. During an interview, on 03/17/2026 at 2:52 P.M., Resident D indicated he had his call light on because he needed to use the restroom. He didn't make it and urinated on himself. He also had to have a bowel movement and almost didn't make it on the bedpan. During an interview, on 03/19/2026 at 9:49 A.M., CNA 3 indicated any staff member could answer call lights and they should be answered timely. The current, undated, facility policy titled, DIGNITY, was provided by the Regional Nurse Consultant on 03/19/2026 at 1:18 P.M. The policy indicated, .Residents are to have all aspects of their dignity maintained by staff regardless of the resident's cognitive level or ability to realize or understand what is being said or done by others. The current, undated, facility policy titled, CALL LIGHTS, was provided by the Regional Nurse Consultant on 03/19/2026 at 1:18 P.M. The policy indicated, .It is the policy of the facility to have a system in place to allow the staff to respond promptly to a resident's call for assistance.All facility staff must be oriented to and aware of the call light system.Call lights are to be answered promptly by staff who see that the call light has been activated.Even if you are unable to meet the need of a resident, you can report the need to the appropriate staff member. This citation relates to Intake 2798581. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(a).

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on record review and interview, the facility failed to accommodate a resident's needs related to transportation for 1 of 14 residents reviewed for accommodation of needs. (Resident D)Findings include:The clinical record for Resident D was reviewed on 03/17/2026 at 9:30 A.M. An admission Minimum Data Set (MDS) assessment, dated 12/12/2025, indicated the resident was cognitively intact. The resident's diagnosis included, but was not limited to, cellulitis of the lower limb (presents of painful, warm, and expanding red inflammation, often accompanied by edema/swelling).A physician's order, dated 12/10/2025 through 12/12/2025, indicated staff were to schedule an appointment for the resident to see a lymphedema (chronic swelling, typically in legs or arms, caused by a blockage or damage to the lymphatic system) specialist. A Progress Note, dated 12/12/2025 at 3:23 P.M., indicated the staff member had tried to call about a lymphedema appointment. There was no answer. A physician's order, dated 12/16/2025 through 12/18/2026, indicated staff were to schedule an appointment for the resident to see a lymphedema specialist. A physician's order, dated 01/09/2026 through 01/12/2026, indicated staff were to schedule an appointment for the resident to see a lymphedema specialist. A Progress Note, dated 01/09/2026 at 1:14 P.M., indicated the Nurse Practitioner saw the resident that day and a new order was obtained to refer the resident to a lymphedema specialist. A Social Service Progress Note, dated 01/13/2026 at 3:11 P.M., indicated the writer contacted the lymphedema office to schedule an appointment. The office indicated there was currently a wait list, but they would attempt to schedule the resident as soon as an appointment was available. The writer would follow-up as needed. A physician's order, dated 02/11/2026 through 02/14/2026, indicated staff were to schedule an appointment for the resident to see a lymphedema specialist. A Social Service Progress Note, dated 02/12/2026 at 11:06 P.M., indicated the writer left a message for the lymphedema office to follow-up on the resident's status on the wait list and to request any updates regarding the appointment availability. The writer was awaiting a return call. A Social Service Progress Note, dated 02/27/2026 at 3:53 P.M., indicated the writer continued to secure an appointment for the resident at a lymphedema clinic. The writer contacted a local office for updated availability and the office reported they were several months behind and continue to have no openings for facility visit appointments at that time. The writer also contacted a local fire department regarding transportation options for the resident to attend a lymphedema clinic in another town. The fire department indicated due to the resident's bariatric weight; the current stretcher was not safe to transport the resident. They indicated they had a new bariatric stretcher ordered to safely transport the resident to appointments and were waiting for it to be delivered. A Social Service Progress Note, dated 03/16/2026 at 2:17 P.M., indicated the writer contacted the transport service to follow-up on the delivery status of the bariatric stretcher. It was reported that it had not been delivered at that time and they would notify the writer once the delivery had been made. The writer would continue to follow-up as needed to support safe transport for the resident. The clinical record lacked indication the physician had been notified regarding the resident not being able to make it the lymphedema specialist. During an interview, on 03/19/2026 at 10:34 A.M, the SSD indicated she had been trying to find transportation for Resident 3 to go the lymphedema specialist. The local office was not taking any new patients. She had found a place in another town, but the resident's wheelchair didn't fit on the facility bus so he would have to go by stretcher. The local fire department the facility utilized had to get a bariatric stretcher for the resident to be transported. They were the only place the facility used to transport residents to appointments. She called them weekly to check on the status of the bariatric stretcher. During an interview, on 03/19/2026 at 2:15 P.M., the Administrator indicated when they were admitting a new resident to the facility, the liaison would send all the resident's information to the facility prior to the admission. The facility would review the information to ensure they had the appropriate equipment to care for the resident. The facility had their own bus they used to transport residents to appointments but could also use a local ride service or the local fire department. There (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were also other transport services they could reach out to if needed. The current facility policy titled, GUIDELINES TO ENSURE REASONABLE ACCOMODATION OF NEEDS dated 06/20/2023, was provided by the Regional Nurse Consultant on 03/19/2026 at 1:18 P.M. The policy indicated, .It is the intent of this facility to provide, at minimum, reasonable accommodations.for those persons (residents) residing in the nursing home facility. The resident has the RESIDENT RIGHT to receive care and services with reasonable accommodation of needs and preferences except when the health or safety of the resident could be jeopardized. This citation relates to Intake 2737502. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(v)(1).

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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 record review and interview, the facility failed to notify the physician of a change in residents' conditions related to blood pressures and blood glucose levels for 2 of 14 residents reviewed for notification of change. (Residents B and C) Findings include:1. Resident B's clinical record was reviewed on 03/17/2026 at 10:30 A.M. An admission Minimum Data Set (MDS) assessment, dated 10/15/2026, indicated the resident's diagnosis included, but was not limited to hypertension (high blood pressure). The resident's MD orders included, but were not limited to, an order with a start date of 10/18/2025 that was discontinued on 01/03/2026, for hydralazine, 100 milligrams (mg). The resident was to receive the medication three times a day for hypertension. Nursing staff were to notify the MD if the resident's systolic (top number/heart at work) blood pressure was over 180 millimeters of mercury (mmHg). The resident's December 2025 Electronic Medication Administration Record (EMAR) was reviewed and indicated the resident's systolic blood pressure was over 180 mmHg on the following dates and times: - On 12/07/2025 at 7:00 A.M., the resident's systolic blood pressure was 210 mmHg,- On 12/12/2025 at 7:00 A.M., the resident's systolic blood pressure was 186 mmHg,- On 12/14/2025 at 5:00 P.M., the resident's systolic blood pressure was 188 mmHg,- On 12/19/2025 at 7:00 A.M., the resident's systolic blood pressure was 189 mmHg, and- On 12/20/2025 at 7:00 A.M., the resident's systolic blood pressure was 189 mmHg. The resident's EMAR and Progress Notes lacked documentation the MD was notified of the above listed systolic blood pressures. 2. Resident C's clinical record was reviewed on 03/17/2026 at 11:00 A.M. A Comprehensive MDS assessment, dated 02/09/2026, indicated the resident was cognitively intact. The resident's diagnosis included, but was not limited to, diabetes (persistently high blood sugar levels). The resident's current MD orders included, but were not limited to, an open-ended order, with a start date of 01/29/2026, to check and record the resident's blood glucose (BG) level four times a day (8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M.). Nursing staff were to call the MD if the resident's BG was less than 60 or above 350. The resident's February and March 2026 EMAR were reviewed and indicated the resident's BG level was above 350 on the following dates and times:- On 02/01/2026 at 12:00 P.M., the resident's BG level was 376,- On 02/02/2026 at 8:00 A.M., the resident's BG level was 425; at 12:00 P.M., the resident's BG level was 436; and at 8:00 P.M., the resident's BG level was 442,- On 02/04/2026 at 8:00 P.M., the resident's BG level was 360,- On 02/07/2026 at 8:00 A.M., the resident's BG level was 364; and at 12:00 P.M., the resident's BG level was 376,- On 02/11/2026 at 12:00 P.M., the resident's BG level was 400,- On 02/16/2026 at 8:00 P.M., the resident's BG level was 383,- On 02/21/2026 at 12:00 P.M., the resident's BG level was 400,- On 02/22/2026 at 8:00 P.M., the resident's BG level was 479,- On 02/24/2026 at 12:00 P.M., the resident's BG level was 385,- On 02/27/2026 at 8:00 P.M., the resident's BG level was 363,- On 03/04/2026 at 8:00 A.M., the resident's BG level was 399; at 12:00 P.M., the resident's BG level was 395; and at 8:00 P.M., the resident's BG level was 381,- On 03/05/2026 at 8:00 P.M., the resident's BG level was 396,- On 03/06/2026 at 12:00 P.M., the resident's BG level was 376,- On 03/12/2026 at 12:00 P.M., the resident's BG level was 398,- On 03/15/2026 at 4:00 P.M., the resident's BG level was 400,- On 03/16/2026 at 12:00 P.M., the resident's BG level was 398; at 4:00 P.M., the resident's BG level was 392; and at 8:00 P.M., the resident's BG level was 444. The resident's EMAR and Progress Notes lacked documentation the MD was notified of the above listed BG levels. During an interview, on 03/18/2026 at 1:03 P.M., Licensed Practical Nurse (LPN) 8 indicated if a resident had an order to notify the MD related to a resident's blood pressure or blood glucose levels, below or above a certain range, there was a place in the computer for documentation. Nurses would enter the blood pressure or blood glucose levels in the computer and indicate if the MD was notified and if there were any new orders. It would show up in the resident's progress notes and on the EMAR as well. The current, undated facility policy, titled Change in Resident's Condition or Status was provided by the Regional (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Consultant on 03/19/2026 at 1:18 P.M. The policy indicated, .The nurse will notify the resident's attending physician when. Any result of a specifically ordered diagnostic test/evaluation that is outside normal parameters. 410 IAC (Indiana Administrative Code) 16.2-3.1-5(a)(3) This citation relates to Intake 2788021

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to initiate a resident's baseline care plan related to dialysis for 1 of 18 residents reviewed for care plans. (Resident 58)Findings include:During an interview, on 03/15/2026 at 12:20 P.M., Resident 58 indicated he was admitted to the facility about three weeks ago and was going to dialysis a few times a week. The clinical record for Resident 58 was reviewed on 03/17/2026 at 9:37 A.M. An admission Minimum Data Set (MDS) assessment, dated 03/08/2026, indicated the resident was severely cognitively impaired. The resident's diagnosis included, but was not limited to, end stage renal disease (chronic kidney disease where kidneys function at less than 15% of normal capacity). The resident admitted to the facility on [DATE]. The resident's hospital records were provided by the Regional Nurse Consultant on 03/18/2026 at 11:08 A.M. The records indicated the resident had received dialysis while in the hospital. The clinical record lacked a baseline care plan for the resident on dialysis. During an interview, on 03/18/2026 at 1:25 P.M., the MDS Coordinator indicated baseline care plans were developed within the first 48 hours of admission and the complete care plan was developed up to 21 days later. If the resident was receiving dialysis a baseline care plan should have been completed. The nurse failed to initiate a dialysis care plan. The current, facility policy, titled Baseline Care Plan Assessment/Comprehensive Care Plans was provided by the Regional Nurse Consultant on 03/19/2026 at 1:34 P.M. The policy indicated, .It is the policy of the facility to ensure that every resident has a Baseline Care Plan completed and implemented within 48 hours of admissions.and will address areas of imminent concerns.410 IAC (Indiana Administrative Code) 16.2-3.1-35 (b)(1)

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	155233	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Batesville, The	958 E Hwy 46 Batesville, IN 47006

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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 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 record and interview, the facility failed to follow physicians' orders related to hold parameters for a cardiac medication and monitoring a resident's weights for 2 of 14 residents reviewed for quality of care. (Residents C and D)Findings include:1. Resident C's clinical record was reviewed on 03/17/2026 at 11:00 A.M. A Comprehensive Minimum Data Set (MDS) assessment, dated 02/09/2026, indicated the resident's diagnoses included, but were not limited to, renal insufficiency (kidneys underperforming) and diabetes (high blood sugar levels). The resident's current MD orders included, but were not limited to, an open-ended order, with a start date of 02/18/2026, for Midodrine 10 milligrams (mg). Nursing staff were to administer the resident's medication three times a day (8:00 A.M, 2:00 P.M., and 8:00 P.M.) only if the resident's systolic blood pressure (SBP; top number) was below 100 millimeters of mercury (mmHg). The resident's March 2026 Electronic Medication Administration Record (EMAR) was reviewed and indicated the resident received the medication when their SBP was above 100 mmHg on the following dates and times: - On 03/03/2026 at 8:00 P.M., the resident's systolic blood pressure was 143 mmHg, - On 03/07/2026 at 8:00 A.M., the resident's systolic blood pressure was 130 mmHg; and at 2:00 P.M., the resident's systolic blood pressure was 138 mmHg, - On 03/08/2026 at 8:00 A.M., the resident's systolic blood pressure was 130 mmHg; and at 2:00 P.M., the resident's systolic blood pressure was 127 mmHg, - On 03/14/2026 at 8:00 A.M., the resident's systolic blood pressure was 132 mmHg; and at 2:00 P.M., the resident's systolic blood pressure was 126 mmHg, and - On 03/16/2026 at 8:00 A.M., the resident's systolic blood pressure was 134 mmHg; and at 2:00 P.M., the resident's systolic blood pressure was 126 mmHg. During an interview, on 03/18/2026 at 1:03 P.M., Licensed Practical Nurse (LPN) 8 indicated If a resident had parameters for cardiac medications, she would assess the resident's blood pressure and/or heart rate before she administered the medication. If anything was out of range, she would not administer the medication. There was a place on the EMAR to indicate the medication was not administered and why it wasn't administered. Nursing staff would enter a note and that would show up in the resident's progress notes. If the resident's vital signs were out of range and the resident was symptomatic, she would notify the MD. The current facility policy, titled DRUG ADMINISTRATION--GENERAL GUIDELINES, dated July 2024, was provided by the Regional Nurse Consultant on 03/19/2026 at 1:15 P.M. The policy indicated, .Medications are administered in accordance with written orders of the attending physician. 2. The clinical record for Resident D was reviewed on 03/17/2026 at 9:30 A.M. An admission MDS assessment, dated 12/12/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, respiratory failure (lungs cannot adequately sypply oxygen to the blood or remove carbon dioxide) and cellulitis of the lower limb (infections of the lower leg with swollen (edema), painful, and warm to touch). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An open-ended physician's order, with a start date of 01/20/2026, indicated the staff were to weigh the resident daily for weight monitoring. The January, February, and March 2026 EMAR and clinical record lacked indication the resident's weights were obtained on the following dates: 01/24/2026, 01/25/2026, 01/29/2026, 02/08/2026, 02/12/2026, 02/26/2026, 03/02/2026, 03/07/2026, 03/08/2026, and 03/12/2026. During an interview, on 03/19/2026 at 9:49 A.M., CNA 3 indicated if a resident was ordered to have daily weights, then the CNAs would obtain the resident's weight and report it to the nurse. During an interview, on 03/19/2026 at 10:40 A.M., RN 9 indicated if a resident was ordered to have daily weights, then the resident's weights would be documented in the EMAR or in the resident's clinical record. The current facility policy titled, GUIDELINES FOR OBTAINING RESIDENTS' WEIGHTS with a revision date of 07/24/2023, was provided by the Regional Nurse Consultant on 03/19/2026 at 1:18 P.M. The policy indicated, .Accuracy with weight measurement is essential for residents in the long-term-care setting. Weight measurement is used to calculate energy, protein, and fluid needs. Further, weight is an indicator of nutritional and health status and changes in weight can often indicate other medical changes. Inaccurate weight measurements can result in an increased number of unplanned weight changes in the facility—and can affect the plans of care for the residents.Daily weights mean DAILY, 7 days weekly. Weekly weights mean WEEKLY month to month—record and then report to physician per physician order and/or policy. This citation relates to Intake 2788021. 410 IAC (Indiana Administrative Code) 16.2-3.1-48(a)(6).

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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 follow appropriate infection control guidelines during incontinence care for 1 of 3 residents reviewed for Urinary Tract Infections (UTI). (Resident 18) Findings include:Incontinence care for Resident 18 was observed on 03/18/2026 at 1:58 P.M., with Qualified Medication Aide (QMA) 2 and Certified Nurse Aide (CNA) 3. The staff members gathered supplies, washed their hands, donned gloves, and explained the procedure to the resident. The CNA placed a stack of wet wash cloths on the side rail of the resident's bed. The resident's pajama pants were pulled down to the tops of her knees, and her brief was pulled away from her front. Her legs were close together throughout the process. CNA 3 wiped the front of the resident's periarea (privates) with wash cloths from the front to the back. Several of the washcloths had feces on them. The resident was rolled to her side, QMA 2 held her in place, and CNA 3 removed the resident's brief and wiped the resident's backside. The resident was not dried nor were the folds of her private area parted to ensure they were cleaned thoroughly. The CNA removed her gloves, used hand sanitizer, donned clean gloves, applied a fresh brief, pulled the resident's pants up, removed her gloves, and covered the resident with her blankets. The CNA gathered the trash, washed her hands, and exited the resident's room. During an interview, on 03/18/2026 at 2:14 P.M., Licensed Practical Nurse (LPN) 5 indicated the resident had just completed a regime of Intravenous (IV) antibiotics for a UTI. During an interview, on 03/18/2026 at 2:41 P.M., QMA 2 indicated the process for pericare (incontinence care) for a female, after getting wash rags ready, was to open the labia (folds of tissue), clean one part, flip the rag, clean the other side, flip the rag, and clean the middle. Using a rinse rag, follow the same pattern, then pat dry. They move the resident's legs so they can clean it better. She did not believe Resident 18 had contractures (stiffened muscles, tendons, or other soft tissue). During an interview, on 03/18/2026 at 2:46 P.M., the Assistant Director of Nursing (ADON) indicated the resident did not have contractures. When providing peri-care on a female, the residents legs should be spread apart and their pants taken off in order to get their legs apart. A resident should be wiped until there was nothing on the washcloth. The clinical record for Resident 18 was reviewed on 03/17/2026 at 2:15 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/27/2026, indicated the resident was moderately cognitively impaired. The resident's diagnosis included, but was not limited to, Parkinson's disease (progressive, neurodegenerative movement disorder that occures when brain cells that produce dopamine die leading to tremors, muscle stiffness, slowness of movement, and balance issues). The physician's orders indicated the resident had received the following antibiotics for UTIs: -Bactrim 800-160 milligrams (mg) two times a day for seven days, with a start date of 02/25/2026, and -Meropenem Intravenous Solution 1 gram two times a day for seven days, with a start date of 03/10/2026.The current undated Perineal Care policy indicated, .Separate the labia and clean downward from front to back with one stroke .Repeat the procedure until the area is .clean .Rinse .Pat dry with a .towel .410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to store medications appropriately for 2 of 3 medication carts reviewed, 1 of 1 treatment carts reviewed, and a random observation. (77 Front Treatment Cart, 77 Front Medication Cart, and 39 front Medication Cart). Findings include:1. During the initial tour of the facility, on 03/15/2026 at 9:05 A.M., a medication cup that contained an unknown powder substance was observed sitting on the counter above the desk at the nurses' station, unattended and no staff within sight of the nurses' station. During an interview, on 03/15/2026 at 9:10 A.M., Licensed Practical Nurse (LPN) 10 indicated she was unsure of what was in the medication cup and who placed it on the counter. It may have been nystatin powder (a topical anti-fungal medication). The medication should not have been left out on the counter. 2. During the initial tour of the facility, on 03/15/2026 at 9:05 A.M., the 77 Front Treatment Cart was unlocked. The treatment cart was unattended and no staff were within sight of the cart. The treatment cart contained physician prescribed creams and cleansers labeled with resident names and an assortment of bandages. 3. The 77 Front Medication Cart was observed on 03/15/2026 at 9:13 A.M., with LPN 10. The cart contained a half full Lantus insulin pen belonging to Resident 45. The insulin pen lacked an opened date. Sitting on top of the medication cart were three plastic cups with lids each containing 2 ounces of a dark brown substance, there were no dates or label to identify the substance. During an interview, on 03/15/2026 at 9:15 A.M., LPN 10 indicated the dark substance was chocolate pudding to be used during medication pass and should have been dated. The Lantus insulin pen should have had an opened date, and the treatment cart should have been locked. 4. The 39 Front Medication Cart was observed on 03/15/2026 at 9:25 A.M., with LPN 5 and contained the following loose pills along with a moderate amount of paper debris:- one small round orange tablet,- one small round white tablet, and- one large oval white tablet. During an interview, on 03/15/2026 at 9:27 A.M., LPN 5 indicated there should not be any loose pills in the medication cart. The current MEDICATION STORAGE IN THE FACILITY policy, dated February 2017, was provided by the Regional Nurse Consultant 03/19/2026 at 1:34 P.M. The policy indicated, .Medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations . 410 IAC (Indiana Administrative Code) 16.2-3.1-25(j)410 IAC 16.2-3.1-25(k)(1)410 IAC 16.2-3.1-25(k)(2)410 IAC 16.2-3.1-25(k)(3)410 IAC 16.2-3.1-25(k)(5)410 IAC 16.2-3.1-25(k)(6)410 IAC 16.2-.1-25(o)

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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 follow appropriate infection control guidelines related to Enhanced Barrier Precautions (EBP) for 1 of 3 residents observed for infection prevention. (Resident 6)Findings include:1.a. A wound dressing change for Resident 6 was observed on 03/18/2026 at 1:07 P M., with Licensed Practical Nurse (LPN) 5. The nurse gathered supplies at the treatment cart, entered the resident's room, and placed the supplies on the over bed table. The table also contained squishy gel toys belonging to the resident. The nurse washed her hands, donned clean gloves, prepared a clean garbage bag, removed a blanket from the resident's right leg, and took the resident's soft boot off, placing it under his heel. The resident's right ankle was wrapped in gauze. The nurse placed scissors, a pen, and the wound dressing supplies on the over bed table. The nurse indicated she had forgotten to bring an Abdominal (ABD) gauze pad for the dressing change, removed her gloves, and left the room to retrieve one. The nurse reentered the room carrying an opened, not packaged, ABD pad in her bare hand. She laid the pad on the over-bed table, washed her hands, donned clean gloves, picked up the scissors, cut the old dressing on the resident's foot, unwrapped the foot, and threw the old dressing materials in the trash. The nurse cleaned the small wound on the back of the heel with normal saline and removed her gloves. She opened the treatment packages, donned clean gloves, administered the treatment, applied the ABD pad to the back of the heel, and began wrapping the heel and ankle with rolled gauze. The nurse dropped the rolled gauze on the floor, removed her gloves, and left the room to get a new roll of gauze. She reentered the room with a new package of rolled gauze, washed her hands, donned clean gloves, and wrapped the resident's right ankle with the rolled gauze. The LPN's hair was touching the resident's foot at times during the dressing change. The nurse applied tape to hold the gauze in place and applied the resident's soft boot. During an observation and interview, immediately following the dressing change, LPN 5 was shown the Enhanced Barrier Precautions sign on the outside of the resident's room door. The nurse indicated she was not aware of the resident being in EBP. The sign indicated staff were to wear a gown and gloves when providing care to the resident. Resident 6 was the only resident assigned to the room. During an interview, on 03/19/2026 at 9:27 A.M., the Assistant Director of Nursing (ADON) indicated Resident 6 had an infection in his wound on his heel awhile back. The clinical record for Resident 6 was reviewed on 03/19/2026 at 9:41 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/17/2025, indicated the resident was rarely/never understood. The resident's diagnosis included, but was not limited to, obstructive hydrocephalus (buildup of cerebrospinal fluid caused by a physical blockage within the brain's ventricular system which can lead to permanent damage). The resident was at risk for pressure ulcers and had one unhealed stage 2 (Partial-thickness skin loss with exposed dermis, presenting as a shallow open ulcer) pressure ulcer that was not present on admission to the facility. 1.b. Resident 6 was observed for medication administration on 03/18/2026 at 11:07 A.M. LPN 5 indicated the resident was to receive medication and a nutritional supplement through his feeding tube. The resident's door had a sign that was visible upon entry that indicated staff were to STOP and that the resident was in ENHANCED BARRIER PRECAUTIONS. Everyone must wear gloves and a gown when providing care, including device care or use of a feeding tube. LPN 5 entered the resident's room and administered a liquid medication and a container of a nutritional supplement through the resident's feeding tube without donning a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 03/19/2026 at 12:48 P.M., the ADON indicated staff were to wear a gown and gloves when providing care for a resident on EBP. That included during a wound treatment, catheter care, or dealing with a feeding tube. The current facility policy, titled 'GUIDELINES for ENHANCED BARRIER PRECAUTIONs (EBP) An extension of Personal Protective Equipment (PPE) with a revision date of December 2022, was provided by the Regional Nurse Consultant on 03/19/2026 at 3:00 P.M. The policy indicated, .It is the policy of the facility to ensure that additional and appropriate PPE (Personal Protective Equipment) is utilized, when indicated, to prevent the spread of Multidrug-resistant Organisms also known as MDROs. Examples of High Contact Resident Care Activities at which time EBP is to be practiced are.Dressing care/changes/management of dressings.feeding tubes. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)