STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155275	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Princeton, The	1020 W Vine St Princeton, IN 47670

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interview and record review, the facility failed to ensure medications were properly dated and labeled, failed to keep medications refrigerated until opening, and failed to destroy expired medications for 3 of 4 medication carts observed. (west hall medication cart and east halls medication carts) Findings include: 1. During an observation on 1/13/26 at 9:06 A.M., the following items were observed in the East back hall cart:Symbicort inhaler (no label) dated 9/28/25Humalog vial (no label or open date)loose medications:pink round tablet, imprint CL75white round tablet, imprint EP136white round tablet, imprint 1 (opposite side) 2white round tablet, imprint RE23orange round tablet, imprint 40 (opposite side) Hyellow oval tablet, imprint 18 (opposite side) Awhite oval tablet, imprint MA (opposite side) 3pink round tablet imprint RA 06orange round tablet imprint 128 (opposite side) Rorange round tablet imprint PH 034yellow round tablet imprint 7 98white round tablet imprint 50white oval tablet imprint 91 (opposite side) F 2. During an observation on 1/13/26 at 9:18 A.M., the following medications were observed in the East front hall cart:antacid liquid bottle (no label and no open date)box of sumatriptan 25 mg tablets (no label no open date) expired on 6/2025loose medications:white round tablet, no imprintyellow round tablet, imprint 81oval orange tablet imprint 20 (opposite side) 1010oval white tablet 3. During an observation on 1/13/26 at 9:30 A.M., the following medications were observed in the [NAME] Hall cart:Insulin Lantus vial - opened, no opened dateInsulin Basaglar pen not opened and not refrigerated (label states refrigerate until open) Two open insulin Basaglar pens (no open date)Insulin Degludec pen, dated open 12/4/25 expired 1/4/26Anora inhaler dated 11/11/25 no patient name or pharmacy labelAnora inhaler dated 1/8/25 no patient name or pharmacy labelAlbuterol sulfate inhaler no date, patient name, or pharmacy labelAlbuterol sulfate inhaler dated 12/18, no pharmacy label 4 packets of polyethylene glycol no patient name or pharmacy labelsloose medications:white round tablet imprint 209white round tablet PH 020white round tablet RE 23white round tablet no imprintin narcotic box: cup labeled [resident 39] oxy yellow round tablet with imprint 230 During an interview on 1/13/26 at 9:40 A.M., RN 5 indicated she was not sure where the loose narcotic medication came from, did not place pill in drawer and could not find where it was signed out of the narcotic medication administration book. On 1/16/26 at 1:46 P.M., the Administrator provided a policy titled Medication Storage in the Facility, dated 2/17, that indicated Medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medications requiring refrigeration or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in a refrigerator. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock by the facility. On 1/16/26 at 1:46 P.M., the Administrator provided a policy titled Prescription Labels, dated 2/17, that indicated Each prescription medication label includes: Resident's first and last name, Drug name, Strength of medication dispensed, Directions for use, including route of administration. Please refer to Medication Administration Record (MAR) for any and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	all lengthy directions that cannot be completely transcribed onto the direction portion of the pharmacy label, Injectable medications will include strength per milliliter (mL) and the amount to be given in mL equivalent on label, Liquid medications will include strength per mL and the amount to be given in mL equivalent on label, Physician's name, Date medication dispensed, Quantity being dispensed, Expiration date of prescription, Name, address, and telephone number of provider pharmacy, Prescription number. 3.1-25(j) 3.1-25(m) 3.1-25(o)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that food was served at palatable temperatures for 1 of 1 trays tested for temperature. (200-hall)Finding includes:1. During an interview on 1/12/26 at 10:31 A.M., Resident 5 indicated that she ate in her room and the food was cold by the time it got to her.During an interview on 1/12/26 at 10:55 A.M., Resident 11 indicated that the food was lukewarm when served.During an interview on 1/12/26 at 10:56 A.M., Resident 14 indicated that the food was always cold.During an interview on 1/12/26 at 1:35 P.M., Resident 35 indicated that the food was cold.During an interview on 1/12/26 at 1:45 P.M., Resident 40 indicated that the food was cold.During an interview on 1/13/26 at 8:37 A.M., Resident 8 indicated that the food was always cold. 2. During the Resident Council meeting on 1/13/26 at 1:37 P.M., 10 out of 10 residents indicated that the food was not hot when served. 3. On 1/14/26 at 11:11 A.M., [NAME] 14 was observed taking the temperature of the lunch food on the steam table. Temperatures included, but were not limited to:pork roast - 179 Fahrenheit (F)mixed vegetables - 190 Frice - 200 [NAME] 1/14/26 at 11:43 A.M., a test tray was obtained from the long 200-hall. The food tasted cool. Temperatures were:rice - 128.8 Fvegetables - 136.6 Fpork roast - 118.6 F During an interview on 1/15/26 at 10:10 A.M., the Kitchen Manager indicated that food should only be three to four degrees cooler when served than what it was on the steam table. He indicated a heating element went out on the heating plates and he was waiting for a replacement. On 1/16/26 at 2:21 P.M. the Administrator provided a current Presentation of the Meal policy, dated 3/25/12, that indicated Meals are served attractively, accurately, efficiently, and at the appropriate temperature. 3.1-21(a)(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure documentation was complete and accurate for 1 of 1 residents reviewed for weight loss, 3 of 3 residents reviewed for insulin administration, and 1 of 3 residents reviewed for wounds. (Resident 9, Resident 28, Resident 5, Resident 14, and Resident 36) Findings include:1. On 1/14/26 at 2:16 P.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebrovascular disease, chronic obstructive pulmonary disease (COPD), and major depressive disorder. The most current Annual Minimum Data Set (MDS) Assessment, dated 12/8/25, indicated Resident 9 was cognitively intact, required setup assistance for eating, weighed 175 pounds (lbs), and had a weight loss of 5 Percent (%) or more in the last month or 10% or more in last 6 months. A care conference was completed on 10/9/25 with the resident in attendance. Care conference notes indicated that the plan of care would continue without change. A current nutritional status care plan, dated 12/29/25, included, but was not limited to, the intervention to weigh the resident monthly or per facility protocol. A current potential for weight loss care plan, dated 1/12/26, included, but was not limited to, the intervention to obtain the resident's weight every month and as needed per policy. Physician orders included, but were not limited to:Monthly weight, dated 2/11/25. A weight summary indicated the following weights had been obtained since 1/14/25:4/18/25 - 231 lbs5/2/25 - 231 lbs6/11/25 - 231.5 lbs11/13/25 - 175 lbs (a 24.41% weight loss) The clinical record lacked documentation to indicate a follow up weight had been obtained, the physician and registered dietician had been notified of the weight loss, or interventions had been started. During an interview on 1/15/26 at 9:25 A.M., the Director of Nursing (DON) indicated that the weight obtained on 11/13/25 was probably not accurate. Resident 9 refused getting weighed a lot. On 1/15/26 at 9:55 A.M., Resident 9 was observed being weighed. Resident 9 weighed 263.5 lbs. During an interview on 1/15/26 at 10:03 A.M., the Administrator indicated that the previous DON entered Resident 9's weight wrong. 2. During an interview on 1/12/26 at 2:11 P.M., Resident 28 indicated that nursing staff sometimes checked his blood sugar and gave his insulin late. On 1/13/26 at 11:08 A.M., Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/31/25, indicated Resident (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 was cognitively intact, required supervision for most Activities of Daily Living (ADLs), and received insulin 7 out of 7 days during the lookback period. A care conference was completed on 12/15/25 with the resident in attendance. Care conference notes indicated the plan of care would continue without change. A current diabetes with risk for hypoglycemia and/or hyperglycemia, dated 7/12/25, included, but were not limited to, the following interventions:Check blood sugars per order.Antidiabetic meds per order. Physician orders included, but were not limited to:insulin regular (a short-acting insulin) injection solution pen-injector 100 units per milliliter (units/mL) - Inject as per sliding scale: if 150 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units; 401 - 450 = 14 units; 451 - 500 = 16 units; 501 - 999 = 20 units, subcutaneously before meals for diabetes mellitus, dated 7/11/2. Lantus Solostar (a long-acting insulin) subcutaneous solution pen-injector 100 units/mL - Inject 10 units subcutaneously two times a day for diabetes mellitus, dated 7/11/25. The electronic Medication Administration Record (eMAR) for January 2026 was reviewed and indicated that insulin regular 100 units/mL was given outside of administration time parameters on the following days:1/1/26 - 12:00 P.M. dose was given at 2:09 P.M.1/2/26 - 7:00 A.M. dose was given at 9:42 A.M. and the blood glucose was taken at 5:54 A.M.1/3/26 - 12:00 P.M. dose was given at 1:50 P.M. and the blood glucose was taken at 12:14 P.M.1/3/26 - 5:00 P.M. dose was given at 11:21 P.M.1/4/26 - 7:00 A.M. dose was given at 11:17 A.M.1/5/26 - 7:00 A.M. dose was given at 8:26 A.M. and the blood glucose was taken at 6:02 A.M.1/5/26 - 12:00 P.M. dose was given at 1:22 P.M.1/7/26 - 7:00 A.M. dose was given at 10:04 A.M. and the blood glucose was taken at 5:03 A.M.1/7/26 - 12:00 P.M. dose was given at 1:43 P.M. and the blood glucose was taken at 11:48 A.M.1/8/26 - 5:00 P.M. dose was held due to a blood sugar of 145 that was taken at 10:05 P.M.1/9/26 - 7:00 A.M. dose was given at 8:20 A.M. and the blood glucose was taken at 5:32 A.M.1/9/26 - 5:00 P.M. dose was held due to a blood sugar of 89 that was taken at 9:28 P.M.1/10/26 - 7:00 A.M. dose was given at 8:09 A.M. and the blood glucose was taken at 5:03 A.M.1/10/26 - 12:00 P.M. dose was given at 1:13 P.M.1/11/26 - 7:00 A.M. dose was given at 8:07 A.M. and the blood glucose was taken at 5:17 A.M.1/11/26 - 12:00 P.M. dose was given at 3:07 P.M.The eMAR for January 2026 was reviewed and indicated that Lantus Solostar 100 units/mL was given outside of administration time parameters on the following days:1/2/26 - 7:00 A.M. dose was given at 9:42 A.M.1/2/26 - 7:00 P.M. dose was given at 9:26 P.M.1/3/26 - 7:00 A.M. dose was given at 9:42 A.M.1/3/26 - 7:00 P.M. dose was given at 11:22 P.M.1/4/26 - 7:00 A.M. dose was given at 11:18 A.M.1/4/26 - 7:00 P.M. dose was given at 9:55 P.M.1/5/26 - 7:00 A.M. dose was given at 8:27 A.M.1/5/26 - 7:00 P.M. dose was given at 8:18 P.M.1/6/26 - 7:00 P.M. dose was given on 1/7/26 at 1:20 A.M.1/7/26 - 7:00 A.M. dose was given at 10:04 A.M.1/7/26 - 7:00 P.M. dose was given at 10:50 P.M.1/8/26 - 7:00 P.M. dose was given at 10:05 P.M.1/9/26 - 7:00 A.M. dose was given at 8:20 A.M.1/10/26 - 7:00 A.M. dose was given at 8:09 A.M.1/11/26 - 7:00 A.M. dose was given at 8:07 A.M.1/11/26 - 7:00 P.M. dose was given at 8:20 P.M.1/12/26 - 7:00 P.M. dose was given at 8:50 P.M. 3. On 1/14/26 at 9:25 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/22/25, indicated Resident (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5 was cognitively intact, was dependent on staff (staff does all the effort) for most Activities of Daily Living (ADLs), and received insulin 7 out of 7 days during the lookback period. A care conference was completed on 10/2/25 with the resident in attendance. Care conference notes indicated that the plan of care would continue without change. A current diabetes with risk for hypoglycemia and/or hyperglycemia, dated 1/7/26, included, but were not limited to, the following interventions:I will have Accu-Cheks (a blood glucometer reading) done per doctors' orders and results will be reported to doctor in a timely fashion if the reading is outside of the parameters provided by the doctor's order.Provide medications as ordered, Accu-Cheks as ordered, assure lab tests are done as ordered, etc. Notify doctor of any complications and abnormalities. Physician orders included, but were not limited to:Lantus Solostar (a long-acting insulin) subcutaneous solution pen-injector 100 units per milliliter (units/mL) - Inject 28 units subcutaneously in the morning for diabetes mellitus, dated 5/9/24. Lantus Solostar subcutaneous solution pen-injector 100 units/mL - Inject 15 units subcutaneously at bedtime for diabetes mellitus, dated 8/1/25.Novolog (a rapid-acting insulin) subcutaneous solution cartridge 100 units/mL - Inject 7 units subcutaneously before meals for diabetes mellitus - hold if blood Accu-chek is less than 80, dated 7/1/2.Check blood sugar before meals and at bedtime before meals and at bedtime for diabetes, dated 1/29/24. The electronic Medication Administration Record (eMAR) for January 2026 was reviewed and indicated that Lantus Solostar 28 units was scheduled for 7:00 A.M. daily and given outside of administration time parameters on the following days:1/2/26 - given at 9:34 A.M.1/3/26 - given at 10:37 A.M.1/5/26 - given at 8:13 A.M.1/7/26 - given at 9:16 A.M.1/14/26 - not marked as completed. The eMAR for January 2026 was reviewed and indicated that Lantus Solostar 15 units was scheduled for 8:00 P.M. daily and given outside of administration time parameters on the following days:1/1/26 - given at 9:25 P.M.1/3/26 - given at 10:31 P.M.1/7/26 - given at 10:55 P.M.1/8/26 - given at 10:09 P.M.1/9/26 - given at 11:08 P.M.1/12/26 - given at 10:08 P.M.1/13/26 - given at 11:19 P.M. The eMAR for January 2026 was reviewed and indicated that Novolog 7 units was given outside of administration time parameters on the following days:1/1/26 - 12:00 P.M. dose was given at 2:04 P.M.1/1/26 - 5:00 P.M. dose was given at 6:27 P.M.1/2/26 - 7:00 A.M. dose was given at 9:33 A.M. and the blood glucose was taken at 5:53 A.M.1/3/26 - 7:00 A.M. dose was given at 10:37 A.M. and the blood glucose was taken at 6:03 A.M.1/3/26 - 12:00 P.M. dose was given at 2:14 P.M. and the blood glucose was taken at 12:14 P.M.1/3/26 - 5:00 P.M. dose was given at 11:27 P.M. and the blood glucose was documented at that time as 136 and 2201/4/26 - 5:00 P.M. dose was given at 6:22 P.M.1/5/26 - 7:00 A.M. dose was given at 8:13 A.M. and the blood glucose was taken at 6:04 A.M.1/5/26 - 12:00 P.M. dose was given at 1:26 P.M.1/7/26 - 7:00 A.M. dose was given at 9:15 A.M. and the blood glucose was taken at 5:06 A.M.1/7/26 - 12:00 P.M. dose was given at 2:00 P.M. and the blood glucose was taken at 11:48 A.M.1/7/26 - 5:00 P.M. dose was given at 10:54 P.M. and the blood glucose was taken at 6:29 P.M.1/8/26 - 5:00 P.M. dose was given at 10:08 P.M. and the blood glucose was documented at 10:08 P.M. as 164 and at 10:09 P.M. as 224.1/9/26 - 12:00 P.M. dose was given at 8:31 P.M. and the blood glucose was taken at 11:30 A.M.1/9/26 - 5:00 P.M. dose was given at 5:37 P.M. and the blood glucose was taken at 9:36 P.M.1/13/25 - 12:00 P.M. dose was given at 2:15 P.M. and the blood glucose was taken at 11:02 A.M.1/14/26 - 7:00 A.M. dose not marked as complete. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/15/26 at 1:50 P.M., the Director of Nursing (DON) indicated that insulin could be administered anytime between one hour before and one hour after it was ordered. Blood glucose checks should also fall within those parameters. During an interview on 1/16/26 at 8:50 A.M., the DON indicated that the internet in the building was horrible and did not reach down all the hallways. Nursing staff sometimes had to administer medications and then document them later. Nursing staff should be documenting insulin administration in real time or if necessary, they should back chart to reflect the accurate administration time. 4. On 1/13/26 at 1:22 P.M., Resident 36's clinical record was reviewed. Resident 36 was admitted on [DATE]. Diagnoses included, but were not limited to Hidradenitis Suppurativa. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/14/25, indicated Resident 36 was cognitively intact, required supervision from staff for toileting and transfers, and had open skin lesions. Current physician orders included, but were not limited to: Cleanse right inguinal wound with normal saline and apply silver alginate and ABD pad twice a day and as needed every day and evening shift for hidradenitis suppurativa and as needed for hidradenitis suppurativa Start date 12/5/2. Cleanse left axillae lower with Vashe (normal saline if not available) apply silvadene 1% cream and silver alginate then ABD pad and rolled gauze twice a day and as needed, Nystatin powder to peri wound every day and evening shift for hidradenitis suppurativa AND as needed for hidradenitis suppurativa Start date 10/16/25. Cleanse right axillae with Vashe (or normal saline if not available)and apply silvadene 1% cream, silver alginate, and border gauze twice a day and as needed every day and evening shift for hidradenitis suppurativa and as needed for hidradenitis suppurativa Start date 10/16/25. The electronic Treatment Administration Record (eTAR) for November and December 2025 and January 2026 was reviewed and indicated that the following dates and times the resident was in the building, the wound dressings were not marked as administered or refused in the TAR or progress notes: 11/3/25 day shift. 11/11/25 day shift. 11/12/25 night shift. 11/25/25 day shift. 12/2/25 night shift. 12/3/25 night shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/22/25 night shift. 12/31/25 day shif.t Current care plan included, but was not limited to: Has chronic Hidradenitis Suppurativa with lesions scattered on body with risk of pain. Date Initiated: 5/15/25. A physician progress note, dated 1/14/26 at 5:36 P. M., indicated Resident has a long history of Hidradenitis Suppurativa. No additional signs of infection. During an interview on 1/16/26 at 11:40 A.M., the Director of Nursing indicated wound dressings were changed, they were just not documented. 5. On 1/13/26 at 11:06 A.M., Resident 14's clinical record was reviewed. Diagnoses included, but were not limited to, Diabetes Mellitus Type 2, Chronic Obstructive Pulmonary Disease (COPD), and unspecified dementia. The Current Quarterly Minimum Data Set (MDS) Assessment date 12/29/25 indicated that Resident 14 was cognitively intact. Resident 14 needed supervision for eating, toileting, transferrring, and dressing, and was on insulin. Current physician orders included, but were not limited to: Insulin Lispro Injection Solution (Insulin Lispro)Inject as per sliding scale:if 0 - 149 = 0;150 - 190 = 3;191 - 230 = 6;231 - 270 = 9;271 - 310 = 12;311 - 350 = 15;351+ Notify MD if above 350,subcutaneously with meals for Diabetes Mellitus start date 6/18/25 and discontinue date of 11/25/26. Insulin Lispro Injection Solution (Insulin Lispro) Inject as per sliding scale:if 200 - 250 = 3;251 - 300 = 5;301 - 350 = 7, Notify MD blood glucose if above 350; Hold if Blood glucose is below 200 subcutaneously at bedtime for Diabetes Mellitus. start dated 6/18/25 and d/c on 11/25/25. Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneously two times a day for Diabetes Mellitus start date 7/30/25. Placed on hold 11/25/25. Glucose Oral Gel 40 % (Dextrose)(Diabetic Use)Give 20 gram by mouth every 1 hours as needed for Hypo/Hyperglycemia dated 7/28/25. The most recent care plan the resident had attended was 11/20/25 care plan was reviewed. The current care plan for diabetes mellitus and had potential for complications date 1/6/26. Interventions included, but was not limited to: I will have accuchecks done per doctors' orders and results with be reported to doctor in a timely fashion if the reading is outside of the parameters provided by the [NAME]. Observe for s/sx of hypoglycemia: sweating, cold clammy skin, numbness of fingers/toes/mouth, rapid heartbeat, nervousness, tremors, faintness, dizziness, headache, lightheadedness, slurred (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	speech, confusion, lack of coordination, etc. On 1/13/26 at 11:50 A.m., a grievance form filed on 11/22/25 by a familiy member of Resident 14 was reviewed. The form indicated the family member was concerned why the resident received the 11/20/25 8:00 P.M. scheduled insulins late resulting in the resident having a hypoglycemic episode. The November Medication Administration/Treatment Administration Record (MAR/TAR) indicated Resident 14 had a blood glucose of 217 at 8:00 P.M. Treatment for this blood sugar was to receive 3 Units of Lispro (Short Acting Insulin) for a sliding scale and a scheduled dose of 10 Units of Lantus(Long Acting Insulin) at 8:00 P.M. According to the MAR/TAR the resident did not receive the Lispro and Lantus until 00:15 A.M. on 11/21/25. The Nurses Progress notes lacked documentation of why the medications were given late and if the resident experienced a hypoglycemic episode at any time. During an interview on 1/16/26 at 1:00 P.M., the Adminstrator and Director of Nursing (DON) indicated the insulins were probably given and not documented well. Even when the blood sugar was low there was no documentation that it was low and how the incident was treated. On 1/16/26 at 1:46 P.M., the Administrator provided a current Guidelines for Nursing Documentation policy, dated 5/17/23, that indicated Document regular or baseline observations. Without knowing what is normal for each individual it is impossible to recognize problems and address them in a timely manner . Be timely in your documentation. It is easy to forget details in the bustle of business. Late notes happen. Should you need to document something out of time do it properly and in an orderly manner by first documenting when you are making the late note, then detailing the actual time the event occurred. Never be deceptive and back-date or fake that you are writing at an earlier time . Flow Charts need filled. Every organization has flow charts, do not leave them blank. Also, whenever an unusual event occurs remember to also go to the chart to document your findings. 3.1-50(a)(1)3.1-50(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155275	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Princeton, The	1020 W Vine St Princeton, IN 47670

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents who desired to self-administer their medications were evaluated for capability to self-administer medications for 1 of 1 residents observed with medications in their room. (Resident 11)Finding includes:On 1/12/26 at 10:59 A.M., Resident 11 was observed in his recliner with a bottle of nasal spray, a tube a Neosporin, a tub of Balmex, and a tub of Burt's Beeswax on the bedside table.On 1/14/26 at 11:08 A.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, cellulitis of buttock and chronic obstructive pulmonary disease (COPD).The most recent admission Minimum Data Set (MDS) Assessment, dated 11/3/25, indicated Resident 11 was cognitively intact, required setup assistance from staff for eating and required supervision of staff for transferring, and had one stage two and one stage three pressure ulcer.A care conference was completed on 1/5/26 with the resident in attendance. Care plans were reviewed.The clinical record lacked a self-administration of medication care plan.The clinical record lacked physician orders for nasal spray, Neosporin, Balmex, and Burt's Beeswax.The clinical record lacked a self-administration of medication evaluation.During an interview on 1/15/26 at 9:42 A.M., Resident 11 indicated that staff told him to hide his nasal spray, Neosporin, Balmex, and Burt's Beeswax in a drawer so State wouldn't see it because he was not supposed to have it. He would buy over the counter medications and have them delivered to the facility, and then the staff would take them away. He indicated he had never been offered an evaluation so that he could self-administer his medication and keep them at bedside.During an interview on 1/15/26 at 1:50 P.M., the Director of Nursing (DON) indicated that Resident 11 did not self-administer any medications. He kept buying things and staff kept confiscating them. She had not thought to evaluate Resident 11 for his capability to self-administer medication and could not think of a reason why he shouldn't be evaluated.On 1/16/26 at 9:20 A.M., the Social Service Director provided an admission consent for treatment, dated 10/29/25, that indicated Resident 11 did not want to self-administer his own medications.During an interview on 1/16/26 at 10:04 A.M., the Administrator indicated Resident 11 had not been assessed to self-administer medications nor had he been asked if he wanted to be assessed to self-administer his medications since 10/29/25.On 1/16/26 at 1:46 P.M., the Administrator provided a current undated Self-Administration of Medications By Residents policy that indicated Each resident is offered the opportunity to self-administer his or her medications during the routine assessment by the facility interdisciplinary team . If the resident desires to self-administer medications, an assessment is conducted by an interdisciplinary team . residents may be reeducated and reevaluated for self- medication as determined by resident need or assessment by an interdisciplinary team.3.1-11(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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure as needed (PRN) orders for psychotropic drugs, that were ordered beyond 14 days, included an evaluation of need for the medication after 14 days and indicated a specific duration of use for 1 of 1 residents reviewed for non-pressure related wounds. (Resident 36) Finding includes:On 1/13/26 at 1:22 P.M., Resident 36's clinical record was reviewed. Resident 36 was admitted on [DATE]. Diagnoses included, but were not limited to, Hidradenitis Suppurativa and generalized anxiety. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/14/25, indicated Resident 36 was cognitively intact, required supervision from staff for toileting and transfers, and received antianxiety medication in the seven-day lookback period. Current physician orders included, but were not limited to: Clonazepam (an antianxiety medication) oral tablet 0.5 MG (milligrams). Give one tablet by mouth every 12 hours as needed for anxiety; Start date 5/15/25. The clinical record lacked an evaluation of need for the medication after 14 days and a specific duration of use. During an interview on 1/15/25 at 1:41 P.M., the Director of Nursing indicated Resident 36 did not have an assessment for PRN antianxiety medication, had not used clonazepam since admission, and should have been discontinued. On 1/16/26 at 1:46 P.M. the Administrator provided a policy titled Guidelines for Psychotropic Medication, dated 6/23, that indicated PRN orders for psychotropic drugs will be limited to 14 days, unless the physician identifies and documents rationale to extend the medication beyond 14 days. PRN antipsychotic drugs will be limited to 14 days and will not be renewed unless the physician evaluates the resident for appropriateness of the medication. 3.1-48(a)(2)

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	155275	A. Building B. Wing	01/16/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accuracy of assessments for 2 of 5 residents reviewed for unnecessary medications. (Resident 53 and Resident 12) Findings include: 1. On 1/13/26 at 2:16 P.M., Resident 53's clinical record was reviewed. Resident 53 was admitted on [DATE]. Diagnoses included, but were not limited to, dementia and anxiety.The most recent Quarterly Minimum Data Set (MDS) assessment dated , 11/19/25, indicated Resident 53 was severely cognitively impaired, required substantial supervision (staff do more than half of the work) for toileting and bathing, and received antipsychotic, antidepressant, and antiplatelet medication during the seven day lookback period.Current physician orders included, but were not limited to: Buspirone HCl Oral Tablet 5 MG (an antianxiety medication). Give 5 mg by mouth two times a day for anxiety, start date 9/29/25. The electronic medication administration record (eMAR) indicated Resident 53 received buspirone 5 MG on all seven days of the lookback period.The MDS assessment did not indicate Resident 53 took an antianxiety medication during the seven-day lookback period. The current care plan included but was not limited to: I am at risk for increased anxiousness with need for anxiolytic related to: Anxiety disorder; Observe/document/report PRN any adverse reactions to anti-anxiety therapy Date Initiated: 12/13/25.2. On 1/13/26 at 2:49 P.M., Resident 12's clinical record was reviewed. Resident 12 was admitted on [DATE]. Diagnosis included, but was not limited to, dementia.The most recent Quarterly MDS, dated [DATE], indicated Resident 12 was severely cognitively impaired, required partial assistance from staff for toileting and bathing, and received antipsychotic, antiplatelet, and anticonvulsant medication during the seven day look back period. Current physician orders included, but were not limited to: Tramadol HCl Tablet (an opioid pain medication) 50 MG (milligrams) Give one tablet by mouth every four hours as needed for moderate to severe pain start date 4/16/24. The electronic medication administration record (eMAR) indicated Resident 12 received Tramadol 50 MG on the following dates:11/13/25 at 1800.12/5/25 at 1813. The MDS assessment did not indicate Resident 12 took opioid medication during the seven-day lookback period. Current care plan included, but was not limited to: I am at increased risk for alteration in pain/discomfort or has current pain related to chronic pain. Date Initiated: 12/9/25. During an interview on 1/15/25 at 2:03 P.M., the MDS Coordinator indicated Resident 53's buspirone should have been coded for antianxiety during the seven-day lookback period, and Resident 12's tramadol taken in the 7-day lookback period should have been coded for opioid. During an interview on 1/16/26 at 11:35 A.M., the Regional Support Nurse indicated the facility did not have a policy for MDS Assessments, the facility should follow the RAI (Resident Assessment Instrument).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen services were provided according to physician orders for 2 of 2 residents reviewed for respiratory care. Oxygen tubing not date. (Resident 11, Resident 14) Findings include:1. During a random observation on 1/12/26 at 11:08 A.M., Resident 14 was observed sitting in recliner with a nasal cannula had oxygen (O2) at 2.5 liter in his nose. The O2 and nebulizer tubing had no dated label, and the water bottle hooked onto the O2 concentrator had the date of 1/5/26. On 1/13/26 at 11:08 A.M., Resident 14's clinical record was reviewed. Diagnoses included but were not limited to, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type 2, and Dementia. The Current Quarterly Minimum Data Set (MDS) Assessment date 12/29/25 indicated Resident 14 was cognitively intact. Resident 14 needed supervision for eating, toileting, transferrring, and dressing, also required oxygen. Current physician orders included, but were not limited to: Change and date nebulizer tubing once a week on Sunday night shift dated 11/22/25. Change O2 tubing weekly on Sunday night shift one time a day every Sunday. Change & date O2 & Hand Held Nebulizer (HHN) tubing weekly on Sunday night shift dated 6/19/25. The current care oxygen care plan indicated Resident 14 required the use of supplemental O2 related to COPD and Lung Cancer dated 1/6/26. Interventions included but were not limited to, Administered O2 as per MD order. dated 1/6/26. Monitor concentrator and/or E tank for correct setting of liters dated 1/6/26. During an interview on 1/16/26 at 2:00 P.M., Registered Nurse (RN) 5 indicated oxygen and nebulizer tubing is usually changed on Sundays by the night shift nurses. 2. On 1/12/26 at 10:59 A.M., Resident 11 was observed sitting in his recliner receiving two liters (L) of oxygen via nasal cannula. The oxygen tubing was not dated. At that time, Resident 11 indicated that staff had not changed his oxygen tubing since he was admitted to the facility. On 1/14/26 at 11:08 A.M., Resident 11's clinical record was reviewed. Resident 11 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD). The most recent admission Minimum Data Set (MDS) Assessment, dated 11/3/25, indicated that Resident 11 was cognitively intact, required supervision for transfers, and was not receiving oxygen. An admission Assessment, dated 10/28/25, indicated Resident 11 was not receiving oxygen. A care conference was completed on 1/5/26 with the resident in attendance. Care plans were reviewed. A current risk for cardiac and respiratory distress care plan, dated 12/2/25, included, but was not (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limited to the following intervention:Use oxygen as ordered. The clinical record lacked a physician order for oxygen. A nursing progress note, dated 10/28/25 at 3:31 P.M., indicated Resident 11 arrived at the facility and was breathing room air. A provider note, dated 10/30/25 at 9:12 A.M., indicated that Resident 11 was breathing two L of oxygen via nasal cannula. A nursing progress note, dated 12/26/25 at 1:00 A.M., indicated Resident 11 complained of shortness of breath. Oxygen was set up and resident was placed on two L of oxygen via nasal cannula. On 1/15/26 at 9:42 A.M., Resident 11 was observed sitting in his recliner receiving two L of oxygen via nasal cannula. The oxygen tubing was not dated. During an interview on 1/16/26 at 8:50 A.M., the Director of Nursing (DON) indicated she was unable to find an oxygen order for Resident 11. On 1/16/26 at 1:46 P.M., the Administrator provided a current undated Oxygen Therapy policy that indicated Oxygen therapy is administered by licensed staff only as ordered by a physician or as an emergency measure until an order can be obtained. The physician's order will specify the rate of flow of oxygen . Discard disposable masks, cannulas, and tubing after use or when they become soiled. On 1/16/26 at 1:46 P.M., the Administrator provided a current undated Physician Orders - (Following Physician Orders) policy that indicated It is the policy of the facility to follow the orders of the physician. At the time of admission, the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission. 3.1-47(a)(6)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medications were administered according to physician's orders and professional standard for 3 of 7 residents observed during medication pass. Three medication errors were observed during 39 opportunities for error in medication administration. This resulted in a 10.34% error rate. (Resident 66, Resident 57, and Resident 5) Findings include:1. During a medication administration observation on 1/14/26 at 7:27 A.M., QMA 9 allowed Resident 66 to administer her own Budesonide-Formoterol Fumarate Inhalation; Resident 66 took one puff of the inhaler. On 1/14/26 at 8:23 A.M., Resident 66's clinical record was reviewed. Physician orders included, but were not limited to:Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5 MCG/ACT (micrograms/actuation) two puffs twice a dayThe clinical record lacked a physician orders for Resident 66 to self administer her medication.Resident 66 was not administered the correct dose of the inhaler and QMA 9 did not offer Resident 66 to rinse her mouth out after the inhaler was used. 2. During a medication administration observation on 01/14/26 at 11:29 A.M., RN 5 administered 10 units of insulin glargine (long acting insulin) to Resident 57. On 1/14/26 at 11:52 A.M., Resident 57's clinical record was reviewed. Physician orders included, but were not limited to:Basaglar (Insulin glargine) KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (units/milliliters) Inject 50 units subcutaneously at bedtime for Diabetes Mellitus Start date 9/29/25Novolog (Insulin Aspart) Injection Solution 100 UNIT/ML (short acting insulin) Inject 10 units subcutaneously three times a day for diabetes 5/15/2025RN 5 did not prime the pen needle before the insulin was administer. RN 5 administered the wrong insulin to Resident 57. 3. During a medication administration observation on 01/14/26 at 11:39 A.M. RN 7 administered seven units of insulin lispro (Admelog) to Resident 5. On 1/14/26 at 12:03 P.M. Resident 5's clinical record was reviewed. Physician orders included, but were not limited to:Novolog PenFill Subcutaneous Solution Cartridge 100 UNIT/ML (Insulin Aspart) Inject 7 unit subcutaneously before meals for Hold if Blood Accucheck is less than 80 May substitute Fiasp or Admelog per pharmacy; Start date 7/1/24 RN 7 did not prime the pen needle before the insulin was administered. During an interview on 1/14/26 at 12:07 P.M., the Director of Nursing indicated insulin pen needle should be primed after the needle is attached to the insulin pen. On 1/16/26 at 12:35 P.M., the Administrator provided a policy titled Insulin Pen Injection Administration, dated 2/17, that indicated Check label to verify correct insulin product and patient. Remove pen cap and wipe rubber stopper with alcohol swab. Always use a new needle for each injection. Remove protective tab from needle and screw it into the pen device. To prime: turn the dose selector to 2 units. Hold pen with the needle pointing up and tap the cartridge gently to move air bubbles to the top. Press the button all the way in. A drop of insulin should appear at the tip of the needle. On 1/16/26 at 1:46 P.M., the Administrator provided a policy titled Medication Administration, dated 2/17, that indicated Before the medication pass Review the resident's Medication Administration Record (MAR) Read each order entirely. Remove medication from drawer. If there is any discrepancy between the MAR and the label, check physician orders before administering medication. 3.1-48(c)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, record review and interview, the facility failed to ensure a resident was free from significant medication errors for 1 of 2 residents observed for insulin administration (Resident 57). Resident 57 received the wrong insulin. Finding includes: During a medication administration observation on 01/14/26 at 11:29 A.M., Resident 57's blood sugar was 308; RN 5 administered 10 units of insulin glargine (long acting insulin) to Resident 57. On 1/14/26 at 11:52 A.M., Resident 57's clinical record was reviewed. Physician orders included, but were not limited to:Basaglar (Insulin glargine) KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (units/milliliters) Inject 50 units subcutaneously at bedtime for Diabetes Mellitus Start date 9/29/25Novolog (Insulin Aspart) Injection Solution 100 UNIT/ML (short acting insulin) Inject 10 units subcutaneously three times a day for diabetes 5/15/2025RN 5 administered the wrong insulin to Resident 57. During an interview on 1/14/25 at 12:07 P.M., the facility was notified of the medication error; the Regional Support Nurse indicated Resident 57 would be monitored and an investigation was started. A nursing progress note, dated 1/14/26 1:03 P.M., indicated the physician was notified and recommendations were to continue to monitor resident, check blood sugar every four hours two times and report back if blood sugar is less than 70, continue with medication list ordered. The medication administration record (MAR) indicated Resident 57's blood sugars following the wrong insulin administration were:325 on 1/14/26 at 4 P.M.484 on 1/14/26 at 8 P.M.266 on 1/15/26 at 8 A.M.254 on 1/15/26 at 11 A.M. On 1/16/26 at 1:46 P.M., the Administrator provided an undated policy titled Medication Administration Errors that indicated Upon identification of a medication error the facility will: Complete medication error report form. Notify the physician and family of the medication error. Conduct an investigation regarding how the error occurred. Institute interventions to prevent further recurrence of medication error. 3.1-48(c)(2)

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	155275	A. Building B. Wing	01/16/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to implement proper use of Enhanced Barrier Precautions (EBP) and use of gloves for a random observation of wound care. (Resident 39) Findings include: On 1/15/26 at 1:40 P.M., during an observation of wound care, Registered Nurse (RN) 5 was observed performing the following steps during a dressing change for Resident 39:Donned gloves but did not apply gown for Personal Protective Equipment (PPE) due to the resident being on EBP.Removed old dressing on the resident's right leg. Placed some of the dressing material on the floor using the same gloves.Placed a clean towel under the right leg without changing gloves.Touched the Resident's left leg and removed old dressing with the same gloves.Removed gloves Washed hands with soap and water for 30 seconds and applied new gloves. Placed new gloves and irrigated the underside of the right leg with normal saline x2.Patted the wound with a 2x2 gauze.Used the same gloved hand to apply alginate dressing to right outer right leg wound.Had the same gloves on when irrigated the outer wound with normal saline Then used another 2x2 gauze pad to pat dry the irrigated area.Did not change gloves when grabbed dressing to get new gauze for dressing for legs.Held leg with same gloves and that did not change the gloves.Dropped gauze wrap on the floor and said she would cut above the dressing that was on the floor.Applied elastic wrap dressing with the same gloves.Removed gloves after placing elastive wrap dressing. Did not sanitize before placing new gloves.Placed dressing on left foot and with an adhesive dressing.Removed gloves did not sanitize.On 1/14 26 at 10:39 A.M., Resident 39's clinical record was reviewed. Diagnoses included, but were not limited to, Diabetes Mellitus Type 2, venous insufficiency, and acquired absence of left leg below knee.The Current admission Minimum Data (MDS) assessment dated [DATE] indicated Resident 39 was cognitively intact, needed set up assistance for eating, and supervision for transferring, substantial-maximum assistance for hygiene, and partial to moderate assistance for dressing.Current Physician orders included, but were not limited to:Transmission Based-Droplet Isolation every shift dated 12/31/25.Cleanse Left Below Knee Amputation L BKA) with normal saline, and apply collagen with silver, calcium alginate with silver and border foam bid (two times a day) and prn (as needed) every day and evening shift dated 10/30/25.Wound care one time a day for wound dated 10/9/25The current care plan for wounds or skin openings that require a dressing dated 1/12/26 included interventions that included, but were not limited to:Follow Enhanced Precaution Guidelines when providing care and coming in direct contact with potentially infected material or devices. Direct Care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting and incontinence care. Device use, Catheter, Trach/Vent, central lines, feeding tube, wounds care or any skin opening requiring a dressing.Reinforce proper handwashing, follow personal equipment protocols and educate me and visitors on protocols as needed.During an interview on 1/15/26 at 2:25 P.M., RN 5 indicated she forgot to apply a gown before starting wound care on the resident.During an interview on 1/15/26 at 2:30 P.M., Regional Support Nurse 2 indicated that there should be gloves that should have been changed at least 2 times during the dressing changes.On 1/15/26 at 2:15 P.M., the Administrator provided a current, non-dated policy Enhanced Barrier Precautions. The policy indicated .Enhanced Barrier Precautions (EBP): Enhanced Barrier Precautions are defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of Multidrug-Resistant Organisms (MDROs) in the form of blood or body fluids, onto the hands and/or clothing of the rendering caregiver .Proper hand hygiene is a critical requirement in all aspects of resident care to include any precautions such as universal/standard/contact/droplet/air borne as well as enhanced (EBP).3.1-18(b)3.1-18(l)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure there was not an emergency call light in 6 of 6 public restrooms that could be utiized by residents in 2 of 2 observations. (Back Hallway, East Hallway) Findings Include: On 1/14/26 at 2:30 P.M., the woman's public restroom in the back hallway was observed to have no key or emergency call system. On 1/15/26 at 8:3 A.M., the public restrooms on back hall and east hall public were observed to have no key or emergency call bell systems. During an interview on 1/16/26 at 10:38 A.M., the administrator was not aware of the need to have an emergency call light or key for a public bathroom if could be accessed. She had been told different things. On 1/16/26 at 1:45 P.M., a policy for the call system was asked for and not received. 3.1-19(u)(2)