STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Scottsburg, The	1350 N Todd Dr Scottsburg, IN 47170

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 34231 Based on interview and record review, the facility failed to ensure a resident (Resident B) was informed, in a timely manner, of the cancellation of an appointment for 1 of 3 residents reviewed for resident rights. Findings include: The clinical record for Resident B was reviewed on 2/5/25 at 2:11 p.m. The resident's diagnoses included, but were not limited to, end stage heart failure and anxiety. The progress note, dated 1/29/25 at 8:39 a.m., indicated the resident was upset and angry. She had an appointment with pain management and the appointment was canceled. An attempt was made to explain to the resident that once she was picked up by hospice services, hospice would take over her care and manage her pain which was why the appointment was canceled. The clinical record lacked documentation that the resident was notified of the cancellation of the appointment prior to the day of the appointment on 1/29/25. During an interview on 2/5/25 at 12:50 p.m., the resident indicated she had an appointment with pain management on 1/29/25. It was canceled sometime in January by Licensed Practical Nurse (LPN) 16. No one had told her the appointment had been canceled. She was dressed and waiting for her ride and that was when they told her. During an interview on 2/5/25 at 3:55 p.m., LPN 7 indicated prior to the resident going onboard with hospice, the resident had an appointment set up with pain management. The appointment was evidently canceled, and no one told the resident. The resident had gotten up early that day, fixed her hair, put on makeup, and was waiting for Certified Nurse Aide (CNA) 13 to pick her up. Someone should have explained to the reasoning why she would no longer be going to the pain management doctor. Staff should have advised the resident her appointment was canceled prior to the day of the appointment. The resident did not find out about the canceled appointment until the day of the appointment. During an interview on 2/7/25 at 12:30 p.m., CNA 13 indicated she was not aware the resident's appointment had been canceled until the day of the appointment. The original scheduled appointment was still listed on her transportation log. (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: 155494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Waters of Scottsburg, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N Todd Dr Scottsburg, IN 47170	

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 1:37 p.m., a current, undated copy of the document titled Resident Rights was provided. It included, but was not limited to, Residents have the right to a dignified existence .They have the right to be fully informed of their total health status This Citation relates to Complaint IN00451851 3.1-3(n)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34231

Based on observation, interview and record review, the facility failed to protect the residents' right to be free from verbal abuse by a staff member for 2 of 4 residents reviewed for abuse. (Resident D and Resident L)

Findings include:

1. The clinical record for Resident D was reviewed on 2/6/25 at 11:22 a.m. The resident's diagnoses included, but were not limited to, schizoaffective disorder, psychotic disorder with delusions and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment, dated 11/1/24, indicated Resident D was alert and oriented.

The incident report, dated 1/16/25, indicated Resident D reported concerns with her care provided by Licensed Practical Nurse (LPN) 14. The follow up report, dated 1/23/25, indicated after an investigation was completed related to concerns with care, the facility was unable to substantiate any allegations of abuse.

During an interview on 2/5/25 at 1:25 p.m., Resident D indicated LPN 14 was always argumentative. She had a snotty attitude; the LPN's voice was mean in tone and the LPN was hateful towards her. Resident D showed no signs of any psychosocial distress.

The written statement from Registered Nurse (RN) 15 indicated upon clocking in for work on 1/14/25 at 6:00 p.m., LPN 14 was in the middle of the Eagle Hallway. Resident D was standing next to LPN 14 and Resident D was yelling about a resident being out in the hallway naked. LPN 14 kept talking rudely to Resident D which agitated the resident (Resident D). RN 15 walked down the hallway to try and de-escalate the situation between Resided D and LPN 14. LPN 14 told RN 15 not to bother the resident because the resident was cycling. LPN 14 was cursing while talking about Resident D. The incident was so loud it could be heard at the nurse's station. RN 15 was able to get Resident D to her room and talk with her and get her calmed down. LPN 14 had instigated Resident D's escalated behavior.

During a telephone interview, on 2/7/25 at 2:30 p.m., RN 15 indicated on 1/14/25 after she clocked in for night shift at 6:00 p.m., she came into the nurses' station. She and everyone else at the nurse's station heard loud talking and a commotion. She walked around and looked down and saw LPN 14 standing at the medication cart in the middle of the Eagle Hallway talking to Resident D and cursing. RN 15 walked down the hallway to de-escalate the situation. LPN 14 told RN 15 there was no sense in talking with Resident D. RN 15 was able to remove Resident D away from the situation. LPN 14 was purposefully upsetting Resident D. Resident D was upset because the gentleman across the hall was sitting in his doorway with only a brief on, which RN 15 did address. She could not hear everything LPN 14 had said to resident D; however, RN 15 did hear LPN 14 use inappropriate language towards Resident D. The LPN kept going at the resident to upset her purposefully. LPN 14 was wrong, and residents have the right to be respected. When LPN 14 gave RN 15 report, LPN 14 said loudly, Resident D was just f*cking cycling and would end up being sent out to behavior.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Waters of Scottsburg, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N Todd Dr Scottsburg, IN 47170	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The clinical record for Resident L was reviewed on 2/7/25 at 4:25 p.m. The resident's diagnoses included, but were not limited to, anxiety, chronic respiratory failure with hypoxia and diabetes. The admission MDS assessment, dated 1/15/25, indicated Resident L was alert and oriented. During an interview, on 2/7/25 at 3:33 p.m., Resident L was observed resting in bed with her call light in reach. The resident indicated the things that LPN 14 said to her or about her did not hurt her feelings, but it did make her mad. The resident showed no signs of any psychosocial distress. The written statement from Certified Nurse Aide (CNA) 13 indicated on 1/10/25, CNA 13 had worked the Eagle and [NAME] Hallways with LPN 14. CNA 13 was on her lunch break for 30 minutes. When CNA 13 returned from her lunch break, Resident L had her call light on. LPN 14 was sitting at the desk and stated to CNA 13, Go answer that cry babies light loudly. When she went into the room, Resident L was crying. During an interview, on 2/7/25 at 2:17 p.m., CNA 13 indicated on 1/10/25 she had gone to lunch. Upon her return, Resident L had her call light on, and she could hear the resident yelling help. She went in and the resident asked her if she was the only one working. The CNA told the resident no, that she had been gone on her lunch break and the nurse was here. Resident L reported her light had been on for 30 minutes. The CNA assisted the resident to the bedpan and went over to the Eagle Hallway since the CNA had two other call lights going off over there. The CNA headed back to the [NAME] Hallway and heard LPN 14 say very loudly, Go answer that cry babies light. CNA 13 went to Resident L's room to assist her off the bed pan. The resident asked, why does she [LPN 14] talk about me like that and the resident was tearful. The written statement from RN 5 indicated, on 1/13/25, LPN 14 was on the phone with Resident L's family member. RN 5 heard LPN 14 tell the family member that everything Resident L told her was nothing but lies. LPN 14 went on to tell the family member that Resident L had only needed change for 45 minutes and that per State regulations, the staff were only obligated to toilet the residents every two hours. LPN 14 then screamed down the hallway to the aides and said, shut her [Resident L's] door now because I am not going to listen to her bullsh*t lies and then called the resident a cry baby. During an interview, on 2/7/25 at 2:05 p.m., RN 5 indicated Resident L had called her family member on 1/13/25 about being wet and not being changed timely. On 1/13/25 at the nurse's station around supper time, Resident L's family member called and was talking to LPN 14 related to what her mother reported. LPN 14 told the family member that everything Resident L told her was a bullsh*t lie and that per the State regulations, staff only needed to check the residets every two hours. During LPN 14's conversation with Resident L's family member, Resident L was in her doorway, facing the nurse's station about 20 feet away, and could hear everything being said. After LPN 14 hung up the phone from the residents' family member, she yelled down the hallway shut her f*cking door as she was not going to listen to her bullsh*t lies the rest of the day. On 2/5/25 at 1:37 p.m., a current, undated copy of the document titled Abuse Prevention Program was provided. It included, but was not limited to, Policy .It is the policy of this facility to prevent abuse .Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings .Verbal Abuse .any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance .Neglect .meals the failure to provide, or willful withholding of adequate medical care (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This Citation relates to Complaint IN00452715 3.1-27(a)(3) 3.1-27(b)

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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 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34231

Based on interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with 1150B of the Act for 2 of 4 residents reviewed for reporting abuse allegations. (Resident D and Resident L)

Findings include:

The incident report, dated 1/16/25, indicated Resident D reported concerns with her care provided by Licensed Practical Nurse (LPN) 14. The follow up report, dated 1/23/25, indicated after an investigation was completed, the facility was unable to substantiate any allegations of abuse.

1. The clinical record for Resident D was reviewed on 2/6/25 at 11:22 a.m. The resident's diagnoses included, but were not limited to, schizoaffective disorder, psychotic disorder with delusions and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment, dated 11/1/24, indicated Resident D was alert and oriented.

During a telephone interview on 2/7/25 at 2:30 p.m., RN 15 indicated on 1/14/25, after she clocked in for night shift at 6:00 p.m., she came into the nurses' station. She and everyone else at the nurse's station heard loud talking and a commotion. She walked around and looked down and saw LPN 14 standing at the medication cart in the middle of the Eagle Hallway talking to Resident D and cursing. RN 15 walked down the hallway to de-escalate the situation. LPN 14 told RN 15 there was no sense in talking with Resident D. RN 15 was able to remove Resident D away from the situation. LPN 14 was purposefully upsetting Resident D. Resident D was upset because the gentleman across the hall was sitting in his doorway with only a brief on, which RN 15 did address. She could not hear everything LPN 14 had said to resident D; however, RN 15 did hear LPN 14 use inappropriate language towards Resident D. The LPN kept going at the resident to upset the resident purposefully. LPN 14 was wrong, and residents have the right to be respected. When LPN 14 gave RN 15 report, LPN 14 said loudly, Resident D was just f*cking cycling and would end up being sent out to behavior. RN 15 indicated she did not report the incident when it occurred, but did place a written statement under the office door of the Director of Nursing (DON).

2. The clinical record for Resident L was reviewed on 2/7/25 at 4:25 p.m. The resident's diagnoses included, but were not limited to, anxiety, chronic respiratory failure with hypoxia and diabetes. The admission MDS assessment, dated 1/15/25, indicated Resident L was alert and oriented.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/7/25 at 2:17 p.m., CNA 13 indicated on 1/10/25 she had gone to lunch. Upon her return, Resident L had her call light was on, and she could hear the resident yelling help. The CNA went in, and the resident asked her if she was the only one working. The CNA told the resident no, that she had been gone on her lunch break and the nurse was here. Resident L reported her light had been on for 30 minutes. The CNA assisted the resident to the bedpan and went over to the Eagle Hallway since the CNA had two call lights going off over there. The CNA headed back to the [NAME] Hallway and heard LPN 14 say very loudly, Go answer that cry babies light. CNA 13 went to Resident L's room to assist her off the bed pan. The resident asked, why does she talk about me like that and the resident was tearful. CNA 13 reported the incident to the DON who asked her to write up a statement. During an interview on 2/7/25 at 2:05 p.m., RN 5 indicated Resident L had called her family member on 1/13/25 about being wet and not being changed timely. On 1/13/25 at the nurse's station around supper time, Resident L's family member called and was talking to LPN 14 about what her mother reported. LPN 14 told the family member that everything Resident L told her was a bullsh*t lie and that per the State regulations, staff only needed to check residents every two hours. During LPN 14's conversation with Resident L's family member, Resident L was sitting in her doorway, facing the nurse's station about 20 feet away, and could hear everything being said. After LPN 14 hung up the phone from the residents' family member, the LPN yelled down the hallway shut her f*cking door as she was not going to listen to her bullshit lies the rest of the day. RN 5 indicated she reported the incident to the DON who instructed her to write a statement. The facility reportables reviewed lacked documentation of the above incidents. On 2/5/25 at 1:37 p.m., a current, undated copy of the document titled Abuse Prevention Program was provided. It included, but was not limited to, Policy .It is the policy of this facility to prevent abuse .Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings .Abuse Reporting .All personnel must promptly report any incident or suspected incident of resident abuse .Additionally, the person(s) observing an incident of resident abuse .must IMMEDIATELY report such incidents to the Charge Nurse .The Charge Nurse will immediately report the incident to the Administrator. This Citation relates to Complaints IN00452715 and IN00453240 3.1-28(c)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34231 Based on observation, interview and record review, the facility failed to implement a plan of care for a resident (Resident B) after all the resident's teeth were extracted for 1 of 3 residents reviewed for care plans. Finding includes: The clinical record for Resident B was reviewed on 2/5/25 at 2:11 p.m. The resident's diagnoses included, but were not limited to, end stage heart failure and anxiety. On 2/5/25 at 12:50 p.m., the resident was observed without teeth. The resident indicated she was going to be fitted for dentures since she had all of her teeth pulled on 1/10/25. The progress note, dated 1/10/25 at 2:47 p.m., indicated the residents' mouth was packed with gauze. The resident had some bleeding at that time. The physician's order, dated 1/31/25, indicated the resident may have per resident preference: Chicken noodle soup, ice cream, or pudding, related to having all her teeth pulled on 1/10/25. The clinical record lacked documentation of the implementation a plan of care related to the extraction of all the resident's teeth. During an interview, on 2/6/25 at 10:15 a.m., the Director of Nursing indicated she would assume a care plan would be implemented related to the extraction of all the resident's teeth. On 2/7/25 at 3:00 p.m., the RDO (Regional Director of Operations) provided a current copy of the document titled Baseline Care Plan Assessment/Comprehensive Care Plans dated 9/13/24. It included, but was not limited to, Policy .The Comprehensive Care Plan will further expand on the resident's risks, goals, and interventions using the Person-Centered Plan of Care approach .The Comprehensive Care Plans will be reviewed and updated every quarter at minimum .The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health .issues This Citation relates to Complaints IN00451851 and IN00452480 3.1-35(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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 34231 Based on interview and record review, the facility failed to ensure a resident's (Resident B) diet was changed and implemented in a timely manner for 1 of 3 residents reviewed for dietary. Findings include: The clinical record for Resident B was reviewed on 2/5/25 at 2:11 p.m. The resident's diagnoses included, but was not limited to, hypertension and end stage heart disease. During an interview, on 2/5/25 at 12:50 p.m., Resident B indicated on 1/10/25, she had all of her teeth extracted so she could be fitted for dentures. The progress note, dated 1/10/25 at 2:47 p.m., indicated the resident's mouth was packed with gauze there was some bleeding observed. The physician's order, dated 1/14/25, indicated the resident was to have chicken noodle soup, ice cream, pudding and milk for meals due to having all her teeth pulled on 1/10/25. The clinical record lacked documentation of a change in the resident's ability to eat on 1/10/25 until 1/14/25. During an interview, on 2/6/25 at 10:15 a.m., the Director of Nursing indicated to her knowledge, the resident did not come back with any paperwork from the dentist when she had her teeth extracted. During an interview, on 2/7/25 at 5:46 p.m., Registered Nurse 5 indicated if a resident had returned from an appointment after having all their teeth extracted, with no orders for a diet change, the dentist should be called to get the new diet clarified. This Citation relates to Complaints IN00451851, IN00452480, IN00453276 and IN00452715 3.1-20(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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 34231 Based on observation, interview and record reviewed, the facility failed to ensure a resident's (Resident H) therapeutic diet was followed for 1 of 3 residents reviewed for resident meals. Findings include: The clinical record for Resident H was reviewed on 2/7/25 at 11:44 a.m. The resident's diagnoses included, but were not limited to, diabetes, anxiety and major depressive disorder. The physician's order, dated 3/12/24, indicated the resident was to receive prune juice with her lunch every day. During an interview on 2/6/25 at 1:40 p.m., Resident H indicated she had an order from the doctor to have prune juice every day with her lunch. She had never received the prune juice with her lunch tray. During an interview on 2/6/25 at 2:38 p.m., the Regional Director of the dietary service indicated she would have to go out a purchase some prune juice since the facility currently had no prune juice available. The partial contract for dietary management contract was provided by the Regional Director of Operations on 2/27/25 at 5:48 p.m. It included, but was not limited to, Dining Services and Nurtition Services .Preparation Responsibilities .Preparation of food .to be served by the Client to the .residents .on the premises .including Food Preparation Services relating to therapeutic diets for patients This Citation relates to Complaints IN00452715 and IN00453276. 3.1-20(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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34231 Based on observation, interview and record review, the facility failed to ensure snacks were provided and available for residents for 8 of 10 residents reviewed for dietary services (Residents B, N, O, H, R, P, Q, and S). This deficient practice had the potential to affect 61 of 62 residents who consume food from the faciliy. Findings include: During an interview, on 2/5/25 at 12:50 p.m., Resident B indicated she and her roommate buy their own snacks, and the kitchen never had any to provide. During an interview, on 2/5/25 at 1:05 p.m., Resident N indicated the kitchen never had any snacks to offer so she had purchased her own. During an interview, on 2/6/25 at 9:28 a.m., Resident O indicated the kitchen always was out of orange juice, grape juice, apple juice as well as milk. There were never snacks passed out at night. On 2/6/25 at 9:30 a.m., Certified Nurse Aide (CNA) 9 was observed passing snacks and drinks on the [NAME] Hallway. CNA 9 indicated she had purchased all the snacks on the snack cart because dietary had not provided them for quite some time. The only thing dietary provided were the four-ounce fruit drinks in the cooler. If you go down and ask the dietary department for snacks, they tell us they do not have anything. During an interview, on 2/6/25 at 9:40 a.m., CNA 10 indicated dietary was supposed to send snacks down for the residents and they don't. It had been a constant battle for staff to have snacks for the residents or to get the bare minimum from the dietary department. The dietary department will serve tea for breakfast rather than juice. During an interview, on 2/6/25 at 11:55 a.m., the Director of Nursing indicated the dietary department had not been providing snacks for the residents. Having snacks for the residents had been a struggle since the new company took over. During an observation of the nourishment panty, on 2/6/25 at 12:01 p.m., with the Director of Nursing, the following was observed: - There were five boxes that contained 12 cups of pudding, in a local food store bag on the pantry counter - There were four jars of 48-ounce applesauce, in a local food store bag, sitting on the pantry counter - There were two unopened loaves of bread on the pantry counter (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- There were no meats or peanut butter observed in the pantry During an interview, on 2/6/25 at 1:40 p.m., Resident H indicated she was supposed to get prune juice with her lunch meal and a sandwich for her nighttime snack. The resident indicated she had not been receiving either one as her physician ordered. During an interview, on 2/6/25 at 1:46 p.m., Resident R indicated you don't get snacks at night around here. She had asked the nurse one time for a snack and there were only two sandwiches available for the whole hallway. During an interview on 2/6/25 at 2:38 p.m., the Manager of the dietary service company indicated they provide bulk snacks and take them to the pantry. She had been at the facility for two days and the dietary department had taken down the snacks. Since they provide bulk snacks, they do not follow the mid-morning, mid-afternoon or bedtime snacks. There had also been a lot of staff turnover. They did not have prune juice and would purchase some today. She had purchased peanut butter today and supplied those to the pantry. During an interview, on 2/7/25 at 9:45 a.m., Resident P indicated there had been multiple times over the past couple of months that she had requested a snack and was told they did not have anything to give her or nothing was available. During an interview, on 2/7/25 at 9:54 a.m., Resident Q indicated there had been multiple times when he had asked for a snack before bed and was told there was not any available. During an interview, on 2/7/25 at 10:01 a.m., Resident S indicated he had not been offered any snacks and was unaware he could get snacks. Review of the facility meal schedule indicated on the following areas the time resident meals were served: - Hope Springs (memory care) breakfast at 7:00 a.m.; lunch at 11:45 a.m.; dinner at 5:00 p.m. - Dining Room, breakfast at 7:10 a.m.; lunch at 12:00 p.m.; dinner at 5:10 p.m. - [NAME], breakfast at 7:20 a.m.; lunch at 12:15 p.m.; dinner at 5:20 p.m. On 2/7/25 at 3:05 p.m., the Regional Director of Operations provided a current, undated copy of the document titled Floor Stock & Between Meal Snacks. It included, but was not limited to, Policy .Limited supplies of floor stock items will be provided to the nursing stations to patients/residents will have access to a snack 24 hours a day .Procedure .Dining Services will provide stock .Nursing Services will provide snacks to residents as requested throughout the 24-hour day of service This Citation relates to Complaints IN00452715 and IN00453276. 3.1-21(e)