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	01/29/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to ensure a resident's (Resident F) dignity was maintained for 1 of 3 residents reviewed for resident rights.Findings include:The clinical record for Resident F was reviewed on 1/28/26 at 3:20 p.m. The resident's diagnoses included, but were not limited to, depression and anxiety. The quarterly MDS (Minimum Data Set) assessment, dated 12/23/25, indicated the resident's cognition was intact.The incident report, dated 1/28/26 at 1:10 p.m., indicated Resident F reported that the Social Services Designee (SSD) came into her room with Resident G, and pulled Resident F's privacy curtain open hastily. The SSD then stated to Resident G, see, she [Resident F] is a woman. SSD then told Resident F that she needed to shave her face. Resident F told the SSD not to pull open her privacy curtain without asking.During an interview, on 1/28/26 at 1:30 p.m., Resident F indicated a few days ago that a new roommate (Resident G) moved into the room with her. After a short time, Resident F introduced herself to Resident G. A few hours later, the SSD whipped open Resident F's privacy curtain. The SSD was with Resident G and said, [Resident G's name] this is [Resident F's name], [Resident F's name] is not a man. The SSD then looked at Resident F, in front of Resident G, and told her you need to shave. Resident F indicated she was humiliated and felt horrible. Resident F was in shock at first, then cried. Resident F did not know the SSD had entered until the SSD flung her privacy curtain open. All the other staff knock and say their names. The SSD did not. The written interview from the SSD, dated 1/28/26, indicated it was reported to the SSD on 1/27/26, that Resident G refused to sleep in the room with a man. Resident G was moved into the room with Resident F. The SSD went to see Resident G and speak with her about Resident F not being a man and tried interventions to get Resident F to sleep since Resident F had not slept for 36 hours. The SSD went into the room with Resident G and pulled the privacy curtain. SSD then stated she introduced Resident F to Resident G and Resident G to Resident F and told Resident G that Resident F was a woman. Resident F said due to her facial hair, Resident G may have thought she was a man. The SSD told Resident F that she could get someone to help her shave.The written interview from the SSD lacked documentation of identifying herself to Resident F upon entering the room and asking Resident F for permission to pull back the privacy curtain.On 1/28/26 at 3:06 p.m., the Regional Nurse Consultant provided a current, undated copy of the document titled Your Rights and Protections as a Nursing Home Resident. It included, but was not limited to, Be treated with Respect.You have the right to be treated with dignity and respect.3.1-3(t)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 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 interview and record review, the facility failed to ensure a resident's (Resident B) blood pressure medication was not administered, as ordered by the physician when out of parameters, for 1 of 3 residents reviewed for quality of care. Findings include:The clinical record for Resident B was reviewed on 1/23/26 at 11:07 a.m. The resident's diagnosis included, but was not limited to, atrial fibrillation.The physician's order, dated 10/9/25, indicated the resident was to receive Propranolol (medication used for an irregular heartbeat) HCL (hydrochloride), 20 mg (milligrams) three times a day at 8:00 a.m., 12:00 p.m. and 5:00 p.m. The medication was to be held if the resident's systolic (top) blood pressure (SBP) was less than 110.Review of the November 2025, December 2025 and January 2026 indicated the resident was administered the Propranolol medication when parameter readings were out of the range to administer on the following dates and times:-On 11/17/25 at 8:00 a.m., when the resident's SBP was 106.-On 11/17/25 at 12:00 p.m., when the resident's SBP was 106.-On 11/17/25 at 5:00 p.m., when the resident's SBP was 106.-On 12/24/25 at 12:00 p.m., when the resident's SBP was 105.-On 12/30/25 at 12:00 p.m., when the resident's SBP was 107.-On 01/06/26 at 5:00 p.m., when the resident's SBP was 109.-On 01/16/26 at 5:00 p.m., when the resident's SBP was 107.During an interview, on 1/29/26 at 2:47 p.m., Registered Nurse (RN) 7 indicated all parameters set by the physician must be followed.On 1/29/26 at 1:42 p.m., the Regional Nurse Consultant provided a current copy of the document titled Medication Administration Policy Guideline dated 5/17/21. It included, but was not limited to, Policy.Medications are administrated as prescribed.The licensed nurse is aware of an indication for the resident receiving medication.parameters.Procedure.Medications are administered in accordance with written orders of the attending physician.This Citation relates to Intakes 2712868, 2713745 and 27180833.1-37

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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 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 interview and record review, the facility failed to ensure a resident's (Resident B) medication administration record reflected the administration of narcotic medication; and failed to ensure physician visits for residents' (Resident B, Resident D, Resident E and Resident F) were uploaded, in a timely manner for 4 of 5 residents reviewed for medical records. Findings include:1.The clinical record for Resident B was reviewed on 1/23/26 at 11:07 a.m. The resident's diagnoses included, but were not limited to, subarachnoid hemorrhage with loss of consciousness, paraplegic (Paralysis affecting the lower half of the body), and traumatic brain injury (brain dysfunction). The physician's order, dated 10/9/25, indicated the resident was to receive Modafinil (medication to improve wakefulness) 100 mg (milligrams) daily at 8:00 a.m.Review of the November 2025 medication administration (MAR) and the November 2025 controlled substance record indicated the following:-On 11/04/25 the MAR reflected the administration of the medication but was not signed as given on the controlled substance record.-On 11/27/25 the controlled substance record reflected the administration of the medication at 8:00 a.m. and 8:00 p.m. There was no physician's order in place for the administration of the 8:00 p.m. dose.Review of the December 2025 MAR and the December controlled substance record indicated the following:-On 12/05/25 the MAR reflected the administration of the medication but was not signed as given on the controlled substance record.-On 12/15/25 the controlled substance record indicated the medication was signed out twice at 8:00 a.m. There was no physician's order in place for the additional 8:00 a.m. dose.-On 12/30/25 the controlled substance record reflected the administration of the medication at 8:00 a.m. and 8:00 p.m. There was no physician's order in place for the administration of the 8:00 p.m. dose.-Review of the January 2025 MAR and the January 2025 controlled substance record indicated the following:-On 01/17/26 the MAR reflected the administration of the medication but was not signed as given on the controlled substance record.The resident's clinical record lacked documentation of any physician visits or the physician's nurse practitioner visits for the resident.During an interview, on 1/29/26 at 2:47 p.m., Registered Nurse (RN) 7 indicated a resident's medications could not be administered without a physician's order in place. When a narcotic medication was administered, the narcotic sheet should be signed by the nurse when the narcotic was pulled. After administering the narcotic medication, the nurse should sign the medication as administered on the medication administration record.On 1/29/26 at 3:27 p.m., the Regional Nurse Consultant provided a current copy of the document titled GUIDELINES for Controlled Substance Medications -an Overview dated 7/22/23. It included, but was not limited to, Individual Charting Record.Record each dose at the time of administration.On 1/29/26 at 1:42 a.m., the Regional Nurse Consultant provided a current copy of the document titled Medication Administration Policy Guide dated 5/17/21. It included, but was not limited to, Policy.Medications are administered as prescribed.2. The clinical record for Resident D was reviewed on 1/23/26 at 2:11 p.m. The resident's diagnoses included, but were not limited to, malignant neoplasm of the larynx, liver transplant, diabetes and acute respiratory failure. The resident was admitted to the facility on [DATE].Review of the physician's progress notes and physician's nurse practitioner notes indicated the first documented note in the resident's record was 11/7/25.On 1/29/26 at 1:36 p.m., the DON provided copies of the physician visits for the resident, which were electronically signed by the physician on 1/28/26 at, or after 3:42 p.m.3. The clinical record for Resident E was reviewed on 1/27/26 at 2:29 p.m. The resident's diagnoses included, but were not limited to, paraplegia and traumatic brain injury.Review of the resident's physician progress notes and physician nurse practitioner notes lacked documentation of physician (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and nurse practitioner visits after 5/1/25.4. The clinical record for Resident F was reviewed on 1/28/26 at 3:20 p.m. The resident's diagnoses included, but were not limited to, acute and chronic respiratory failure and congested heart failure Review of the resident's physician progress notes and physician's nurse practitioner notes indicated the resident was last seen on 10/23/25.During an interview, on 1/28/26 at 2:45 p.m., the Director of Nursing (DON) indicated that both the physician and the nurse practitioner had been in to see their residents and was not sure why the notes were not in the record.During an interview, on 1/28/26 at 2:47 p.m., Licensed Practical Nurse (LPN) 3 indicated she had spoken with the physician's nurse practitioner who reported that the notes had been uploaded to the system on their end and would need to be retrieved by the facility.On 1/29/26 at 1:36 p.m., the DON provided copies of the physician visits/nurse practitioner visits for the resident, which were electronically signed by the physician on 1/28/26 at, or after 3:42 p.m.On 1/28/26 at 3:06 p.m., the Regional Nurse Consultant provided a current copy of the document titled Guidelines for PHYSICIAN VISITS in LTC/SNFs dated 4/22/24. It included, but was not limited to, Facts.Physicians play a crucial role in supervising care of the residents.During each required visit, the physician, or non-physician practitioner., must review the resident's total program of care, write, sign and date progress notes.On 1/29/26 at 1:42 p.m., the Regional Nurse Consultant provided a current, undated copy of the document titled Health Records. It included, but was not limited to, Procedure.Each resident will have an active health record. This resident record shall be kept current, complete, legible, and available at all times.A medication administration record shall be maintained which contains the date and time each medication is given.and by whom administered.This Citation relates to Intakes 2712868, 2713745 and 27180833.1-50(a)(1)3.1-50(a)(2)

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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 and interview, the facility failed to ensure a resident's room was adequately equipped with an individual call system device to allow the resident to call for assistance if needed for 1 of 3 residents call systems reviewed. (Resident C)Findings include:The clinical record for Resident C was reviewed on 1/23/26 at 1:52 p.m. The resident's diagnoses included, but were not limited to, anoxic brain injury (the brain was completely deprived of oxygen, causing cells to die), acute respiratory failure with hypoxia (life-threatening condition where the lungs fail to oxygenate the blood) and hypercapnia 9the buildup of too much carbon dioxide in the bloodstream) and anxiety.The care plan, dated 1/13/26, indicated the resident was at risk for falls and to place the resident's call light within reach.During an observation, on 1/28/26 at 1:26 p.m., Resident C was observed resting in bed with eyes closed. Resident C did not have his call light in place. A single call cord was observed in the room with the only call cord in place for the resident's roommate.During an interview, on 1/28/26 at 1:27 p.m., Certified Nursing Assistant (CNA) 5 entered Resident C's room and indicated she did not see a call light for Resident C. The CNA indicated there should have been a split call cord in the room.During an interview, on 1/28/26 at 1:29 p.m., Licensed Practical Nurse (LPN) 6 indicated all residents should have a call light within reach.On 1/29/26 at 1:42 p.m., the Regional Nurse Consultant provided a current, undated copy of the document titled Call Lights. It included, but was not limited to, Policy.It is the policy of the facility to have a system in place to allow staff to respond promptly to a residents' call for assistance.The call system will be available in the resident's room.Procedure.Always be sure that the resident has a functioning call light in an accessible location to where the resident is located in their room.This Citation relates to Intakes 2712868, 2713745 and 2718083 3.1-19(u)