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	03/18/2026

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 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. Based on interview and record review, the facility failed to ensure a resident (Resident E) was informed of a decrease in pain medication; failed to ensure a resident's (Resident M) representative was notified of the discontinuation of therapy services; and failed to ensure a resident's (Resident E) follow-up appointment for suture removal status post amputation was set-up for 2 of 3 residents reviewed for resident rights. Findings include:1 The clinical record for Resident E was reviewed on 3/15/26 at 2:27 a.m. The resident's diagnoses included, but were not limited to, orthopedic after care following surgical amputation, diabetes, chronic pain, depression, acquired absence of left leg above knee and myalgia (pain). The admission MDS (Minimum Data Set) assessment, dated 2/2/26, indicated Resident E's cognition was intact. The hospital history and physical note, dated 1/29/26, indicated Resident E had a left above knee amputation on 1/16/26. The hospital discharge orders, dated 1/29/26, indicated the resident had a follow-up appointment with the vascular nurse practitioner on 2/16/26 The physician's order, dated 2/6/26, indicated the resident was to receive Oxycodone-Acetaminophen (narcotic pain medication) 7.5-325 mg (milligrams) every 6 hours for pain. The physician's order, dated 3/9/26, indicated the resident's order from 2/6/26 was discontinued with a new order for Oxycodone-Acetaminophen 5-325 mg every 6 hours for pain. The clinical record lacked documentation of notification to Resident E about the follow-up appointment, a need to reschedule the follow-up appointment or the decrease of the resident's pain medication. During an interview, on 3/15/26 at 1:17 p.m., Resident E indicated he was not aware that he had a follow-up appointment on 2/16/26. Resident E's social worker from the veteran's administration had visited him and asked him about his follow-up appointment. Resident E told him he had not been to any follow-up appointments. The social worker from the veteran's administration spoke to the staff and he did finally get a follow-up appointment earlier that month. It took the doctor a while to remove his sutures as they were embedded in the skin. Last week, his pain medication had been decreased without his knowledge. The only reason he found out that it had been changed was the pain medication was a different color. When he asked about the medication, he was told by the nurse that the nurse practitioner had decreased it. During an interview, on 3/17/26 at 3:32 p.m., the vascular center indicated Resident E had surgery on 1/16/26. The patient had a follow-up appointment on 2/16/26 which was sent to the facility on discharge. The facility made no contact to reschedule the appointment, and the resident was listed as a no call no show on 2/16/26. The social worker from the veteran's administration had gotten involved and the appointment was rescheduled for 3/5/26 at 1:00 p.m. The resident did not arrive until 3:00 p.m., however, the physician did go ahead and see the resident because he had sutures that needed removed. During an interview, on 3/18/26 at 11:08 a.m., Licensed Practical Nurse (LPN) 10 indicated when there were changes in a resident's medication or care, the resident and/or resident representative should have been informed of those changes. 2. The clinical record for Resident M was reviewed on 3/17/26 at 12:05 p.m. The resident's diagnoses included, but were not limited to, dementia (mental decline) with other behavioral disturbances and lack of coordination. During an interview, on 3/16/26 at 3:23 p.m., Resident M's representative indicated she had requested for therapy to work with her father to help increase his strength and was told they would. She had been to the facility multiple times, for extended periods, and had not seen (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any therapist work with her father. She had no idea what was going on and had not been notified of anything related to his therapy. During an interview, on 3/17/26 at 9:40 a.m., physical therapist 14 indicated he had worked the Resident M for about a month with max potential reached and the resident was discharged from therapy. He did not notify the family because he had given the orders to the nursing staff and the nursing staff were to notify the family. The clinical record lacked documentation of resident or the representative notification related to the resident's discontinuation of therapy. On 3/18/26 at 9:54 a.m., the Executive Director provided a current, undated copy of the document titled Resident Rights. It included, but was not limited to, Policy.It is the policy of the facility to observe and implement RESIDENT RIGHTS as dictated by CMS.Each resident has the right to be treated with dignity and respect.The preferences and goals of the resident should be honored as much as possible and the resident's comfort, safety and overall welfare must be promoted.and enhanced at all times. This Citation relates to Intakes 2743395, 2799515 and 2803955 410 IAC (Indiana Administrative Code) 16.2-3.1-3(h)(2)410 IAC 16.2-3.1-3(h)(3)

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 - Some	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** Based on interview and record review, the facility failed to protect the resident's right to be free from resident to resident abuse for 3 of 4 residents reviewed for abuse. Findings include:1. The clinical record for Resident B was reviewed on 3/15/26 at 2:04 p.m. The resident's diagnoses included, but were not limited to, schizophrenia (chronic, severe brain disorder that affects how a person thinks, feels, and acts), depression, suicidal ideations, and vascular dementia (mental decline). The incident report, dated 3/13/26 at 1:01 p.m., indicated Resident C entered Resident B's room. Resident B, upset, placed hands on Resident C's shoulders to turn her around and slightly pushed her from the back. The progress note, dated 3/13/26 at 1:16 p.m., indicated Resident C entered Resident B's room. Resident B placed his hands on Resident C's shoulder, turned her around and pushed her from the back. During an interview, on 3/15/26 at 12:00 p.m., Staff Member 8 indicated on 3/12/26 in the late afternoon/early evening, she overheard Resident B tell Resident C he was going to kill the resident if she came into his room. Staff Member 8 reported the incident to the Director of Nursing who then told Staff Member 8 to inform Social Services. When Staff Member 8 reported the incident to Social Services, Social Services asked Staff Member 8 what do you want me to do about it. During an interview, on 3/15/25 at 12:05 p.m., Staff Member 9 indicated on 3/13/26 at around 1:00 p.m., Resident C was ambulating down the hallway towards the end of [NAME] Hall. Resident C had not gotten to the end of the hall when Resident B came out of his room. Resident B grabbed Resident C by her neck, twisted her arm behind her back and then pushed her into a geriatric chair that was in the hallway. Resident C tried to get away, but Resident B kept pushing her. Staff Member 9 intervened and assisted Resident C away from Resident B. Staff Member 9 reported the incident to the Director of Nursing and was told it would be reported to the Administrator. During an interview, on 3/15/26 at 1:20 p.m., the Administrator indicated she reported what she had been told. She had not gotten any staff statements on the incident yet. She was unaware that Resident B had threatened Resident C on 3/12/26 prior to the incident on 3/13/26. During an interview, on 3/15/26 at 3:06 p.m., Staff Member 17 indicated on 3/13/26, she was sitting at the nurses' station when Staff Member 9 took off running down the [NAME] Hall. Resident C was walking towards Resident B's room. Resident B grabbed Resident C at the top of her left shoulder area and up on the right side by her neck. Resident B swiveled Resident C around and shoved her three times down the hallway. Staff Member 9 reported to the Director of Nursing exactly what had happened and what Staff Member 17 had witnessed as well. During an interview on 3/17/26 at 2:38 p.m., the Administrator indicated she did not get the whole story on what had happened prior to reporting the incident. She was not sure what the Regional Director of Operations was going to do with regards to the comment Resident B had made to Resident C on 3/12/26. She had been instructed to report that on the five day follow-up. 2.a.The clinical record for Resident C was reviewed on 3/15/26 at 2:17 p.m. The resident's diagnoses included, but were not limited to, traumatic subarachnoid hemorrhage without loss of consciousness, acute pain due to trauma, personal history of traumatic brain injury, affective mood disorder and anxiety. The progress note, dated 3/12/26 at 5:47 p.m., indicated Resident C continued to pace up and down the halls, in and out of residents' rooms, rummaging through their things and disturbing other residents. The resident was very difficult to re-direct and became agitated and loud while swinging her arms at the staff. The incident report, dated 3/13/26 at 1:01 p.m., indicated Resident C entered Resident B's room. Resident B, upset, placed hands on Resident C's shoulders to turn her around and slightly pushed her from the back. 2.b. During an interview, on 3/15/26 at 12:05 p.m., Staff Member 9 indicated on 3/13/26, she had to separate Resident C from Resident D because Resident D had rammed her walker into Resident C's legs and reported the incident to the Director of Nursing. During an interview, on 3/18/26 at 12:04 p.m., Resident D indicated she pushed her walker into Resident C because Resident C had gotten into (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her personal space on 3/13/26. The incident report, dated 3/15/26, indicated it was reported to the Administrator that on 3/13/26, Resident D made contact with Resident C's legs with Resident D's rollator walker. The progress note, dated 3/12/26 at 5:47 p.m., indicated Resident C continued to pace up and down the halls, in and out of residents' rooms, rummaging through their things and disturbing other residents. 3. The clinical record for Resident D was reviewed on 3/16/26 at 12:30 p.m. The resident's diagnoses included, but were not limited to, history of traumatic brain injury and anxiety. The incident report, dated 3/15/26, indicated Resident D made contact with Resident C's legs using her rollator walker. During an interview, on 3/15/26 at 12:05 p.m., Staff Member 9 indicated on 3/13/26, she had to separate Resident C from Resident D because Resident D had rammed her walker into Resident C's legs and reported the incident to the Director of Nursing. During an interview, on 3/17/26 at 2:38 p.m., the Administrator indicated Resident D admitted that she hit Resident C in the leg with her walker because Resident C was in Resident D's personal space. During an interview, on 3/18/26 at 12:04 p.m., Resident D indicated she pushed her walker into Resident C and hit her legs because Resident C had gotten into her personal space. On 3/15/26 at 2:50 p.m., the Executive Director provided a current copy of the document titled Abuse Prevention Program dated 10/22/22. It included, but was not limited to, Policy.It is the policy of this facility to prevent resident abuse.Each resident receives care and services in a person-centered environment in which all individuals are treated like human beings.Abuse Reporting.This facility will not tolerate resident abuse or treatment by anyone, including.other residents.Abuse.the willful infliction of injury.Physical Abuse.Hitting, slapping, pinching, kicking, etc. 410 IAC (Indiana Administrative Code) 16.2-3.1-27(a)(1)410 IAC 16.2-3.1-27(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** Based on interview and record review, the facility failed to ensure complete and accurate information was provided to the abuse coordinator for an allegation of resident-to-resident abuse; failed to ensure an allegation of resident-to-resident abuse was reported to the abuse coordinator; and failed to ensure an allegation of verbal abuse was reported, in a timely manner, for 3 of 4 residents reviewed for abuse. (Resident B, Resident C and Resident D) Findings include:1.On 3/15/26 at 12:00 p.m., Staff Member 8 indicated on 3/12/26 in the late afternoon/early evening, Staff Member 8 overheard Resident B tell Resident C he was going to kill her if Resident C came in his room. Staff Member 8 reported the incident to the Director of Nursing who then told Staff Member 8 to inform Social Services. When Staff Member 8 reported the incident to Social Services, Social Services asked Staff Member 8 what do you want me to do about it. On 3/15/25 at 12:05 p.m., Staff Member 9 indicated on 3/13/26 at around 1:00 p.m., Resident C was ambulating down the towards the end of [NAME] Hall. Resident C had not gotten to the end of the hall when Resident B came out of his room, grabbed Resident C by her neck, twisted her arm behind her back and then pushed her into a geriatric chair that was in the hallway. Resident C tried to get away, but Resident B kept pushing her. Staff Member 9 intervened and assisted Resident C away from Resident B. Staff Member 9 reported the incident to the Director of Nursing and was told it would be reported to the Administrator. On 3/15/26 at 3:06 p.m., Staff Member 17 indicated on 3/15/26, she was sitting at the nurses' station when Staff Member 9 took off running down the [NAME] Hall. Resident C was walking towards Resident B's room. Resident B grabbed Resident C at the top of her left shoulder area and up on the right side by her neck. Resident B swiveled Resident C around and shoved her three times down the hallway. Staff Member 9 reported to the Director of Nursing exactly what had happened and what Staff Member 17 had witnessed as well. The incident report, dated 3/13/26 at 1:01 p.m., indicated Resident C entered Resident B's room. Resident B, upset, placed hands on Resident C's shoulders to turn her around and slightly pushed her from the back. During an interview, on 3/15/26 at 1:20 p.m., the Administrator indicated she reported what she had been told. She had not gotten any staff statements on the incident yet. She was unaware that Resident B had threatened Resident C on 3/12/26. On 3/17/26 at 2:38 p.m., the Administrator indicated she did not get the whole story on what had happened prior to reporting the incident. She was also unaware of the incident between Resident D and Resident C. She was not sure what the Regional Director of Operations was going to do with regards to the comment Resident B had made to Resident C on 3/12/26. 2.During an interview, on 3/15/26 at 12:05 p.m., Staff Member 9 indicated on 3/13/26, she had to separate Resident C from Resident D because Resident D had rammed her walker into Resident C's legs and reported the incident to the Director of Nursing. During an interview, on 3/17/26 at 2:38 p.m., the Administrator indicated Resident D admitted that she hit Resident C in the leg with her walker because Resident C was in Resident D's personal space. During an interview, on 3/18/26 at 12:04 p.m., Resident D indicated she pushed her walker into Resident C and hit her legs because Resident D had gotten into her personal space. The incident report, dated 3/15/26, indicated it was reported to the Administrator that on 3/13/26, Resident D made contact with Resident C's legs with Resident D's rollator walker On 3/15/26 at 2:50 p.m., the Executive Director provided a current copy of the document titled Abuse Prevention Program dated 10/22/22. It included, but was not limited to, Policy.It is the policy of this facility to prevent resident abuse.Each resident receives care and services in a person-centered environment in which all individuals are treated like human beings.Identification .Supervisors shall immediately inform the Administrator or in the absence of the Administrator, the person in charge of the facility of all reports of incidents, allegations .of potential mistreatment. Upon learning of the report, the Administrator or in the absence of the Administrator, the person in charge of the facility shall initiate and incident investigation . 410 IAC (Indiana Administrative Code) 16.2-3.1-28(a)410 IAC 16.2-3.1-28(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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure blood pressure medication was not administered to a resident (Resident K) outside of prescribed parameter blood pressure for 1 of 4 residents reviewed for quality of care. Findings include:1. The clinical record for Resident K was reviewed on 3/17/26 at 11:15 a.m. The resident's diagnosis included, but was not limited to, hypotension (low blood pressure). The physician's order, dated 2/14/26, indicated the resident was to receive Midodrine 10 mg, via gastrostomy tube, three times a day at 6:00 a.m., 2:00 p.m. and 10:00 p.m. for hypotension. The medication was to be held (not administered) for a systolic blood pressure (SBP) greater than 110. Review of the February 2026 medication administration record indicated the medication was administered on the following dates and times:-On 2/16/26 at 10:00 p.m., when the resident's SBP was 122,-On 2/17/26 at 6:00 a.m., when the resident's SBP was 126,-On 2/17/26 at 10:00 p.m., when the resident's SBP was 119, and-On 2/19/26 at 6:00 a.m., when the resident's SBP was 119. During an interview, on 3/18/26 at 11:17 a.m., LPN 12 indicated physician's orders should be followed. This Citation relates to Intake 2743395, 2799515 and 2803955 410 IAC (Indiana Administrative Code) 16.2-3.1-37

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure monitoring was in place for a resident (Residents E, G and K) on anticoagulant therapy and monitoring was in place for a resident (Resident E and Resident F) on insulin 4 of 4 residents reviewed for pharmacy procedures. Findings include:1. The clinical record for Resident E was reviewed on 3/15/26 at 2:47 p.m. The resident's diagnoses included, but were not limited to, diabetes (persistently high blood sugar levels) and status post left above knee amputation. The admission order, dated 1/29/26, indicated the resident was to receive the following medications:-Aspirin (blood thinner) 81 mg (milligrams) daily-Insulin Lispro (long-acting insulin) 5 units subcutaneously with meals-Xarelto (blood thinner) 20 mg daily with breakfast Review of the resident's January, February, and March 2026 medication administrations lacked documentation of nursing staff monitoring the resident for signs/symptoms of bleeding for the blood thinners and for signs/symptoms of hypoglycemia/hyperglycemia for the insulin. 2. The clinical record for Resident F was reviewed on 3/16/26 at 12:50 p.m. The resident's diagnosis included, but was not limited to, diabetes. The physician's order, dated 1/29/26, indicated the resident was to receive Lantus (long-acting insulin) 25 units subcutaneously twice daily at 9:00 a.m. and 9:00 p.m. The clinical record lacked documentation of nursing staff monitoring the resident for signs/symptoms of hyperglycemia/hypoglycemia. 3. The clinical record for Resident G was reviewed on 3/17/26 at 10:50 a.m. The resident's diagnoses included, but were not limited to, chronic embolism (when a blood clot breaks off, travels through the bloodstream, and blocks a vessel elseware) and thrombosis (blood clot)of the right upper extremity. The physician's order, dated 3/11/26, indicated the resident was to receive Apixaban (blood thinner) 5 mg twice daily at 8:00 a.m. and 8:00 p.m. The clinical record lacked documentation of nursing staff monitoring the resident for bleeding from 3/12/26 through 3/16/26. 4. The clinical record for Resident K was reviewed on 3/17/26 at 11:15 a.m. The resident's diagnoses included, but were not limited to, hypotension (low blood pressure) and cardiovascular disease (condition affecting the heart and blood vessels). The physician's order, dated 2/10/26, indicated the resident was to receive Apixaban 5 mg twice daily for cardiovascular health at 8:00 a.m. and 8:00 p.m. The clinical record lacked documentation of the nursing staff monitoring the resident for signs of bleeding. During an interview, on 3/18/26 at 11:08 a.m., Licensed Practical Nurse (LPN) 10 indicated residents who were on blood thinners should be monitored for signs of bleeding and residents on insulin should be monitored for hyperglycemia/hypoglycemia and the monitoring should be documented on the medication administration record. On 3/18/26 at 10:24 a.m., the Executive Director provided a current copy of the document titled Medication Administration Policy Guideline dated 1/25/19. It included, but was not limited to, Policy.Medications are administered as prescribed, in accordance with good nursing principles and practices. This Citation relates to Intake 2743395, 2799515 and 2803955 410 IAC (Indiana Administrative Code) 16.2-3.1-25(b)(2)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure the hall meal service food was held at an appropriate temperature for 2 of 2 observations; failed to ensure the food was not overcooked for 1 of 2 meal service observations; and failed to ensure residents received adequate portions for 7 of 10 residents reviewed for dietary services. This deficient practice had the potential to affect 73 of 78 residents residing in the facility. Findings include:During a kitchen food service observation, on 3/15/26 at 12:25 p.m., the following was observed:-The meatloaf was observed with blackened areas across the top and along the edges in the pan.-The serving portion of the meatloaf provided to the residents measured 3 inches in length, one inch in width with a depth of one inch. During an interview, on 3/15/26 at 1:20 p.m., the Executive Director indicated she was going to have the outsourced Dietary Manager re-educate the kitchen staff on portion sizes. During an interview, on 3/16/26 at 11:40 a.m., Resident E indicated the food served was generally cold, especially breakfast. Last night (3/15/26) for supper, they served soup and the bowl was only filled up a quarter of the way. This morning (3/16/26), he was served one hash brown and 2 sausage links which were cold when it was served to him. During an interview, on 3/16/25 at 10:35 a.m., Resident N indicated after every meal, everyone in still hungry. The portion sizes were so small. This past Sunday, she received a piece of meatloaf, which was equivalent to three bites. For dinner Sunday, they were served a bowl of soup which was only filled up a quarter of the way. If you eat in your room, the food was always cold when you get it, especially the eggs. On 3/17/26 at 8:24 a.m., a random food tray was selected during a food temperature check on the [NAME] Hall with the following temperatures:-Scrambled eggs temperature was 98.8 degrees Fahrenheit-Oatmeal temperature was 149.2 degrees Fahrenheit-Sausage link temperature was 86.4 degrees Fahrenheit During an interview, on 3/17/26 at 10:40 a.m., Resident O indicated the food was cold all the time. This past Sunday, he received a sliver (very small size) of meatloaf that was way overcooked. The food served was not fit for a dog. During an interview, Resident P indicated the food was horrible and they do not give you enough. The portions they serve the residents here were equivalent to what you would serve a young child. During an interview, on 3/17/26 at 10:44 a.m., Resident Q indicated for most of the residents, the meals are the highlight of the day. The quality and quantity the facility served the residents dampens that highlight. The facility kitchen staff just don't give you enough food and the quality of the food was very poor. During an interview, on 3/18/26 at 10:53 a.m., Resident R indicated, twice, the facility had served undercooked food. The portion sizes were so small that she was still hungry after she ate. The meatloaf served on Sunday was equivalent to two or three bites for her. They did not serve the residents enough food. During an interview, on 3/18/26 at 10:55 a.m., Resident S indicated the cafeteria food service was horrible. The quantity served was so small and the food served to the residents' in their rooms was always cold. If it was not for the staff buying other food for us, we would starve. On 3/17/26 at 7:59 a.m., the Executive Director provided a current, undated copy of the document titled Food Temperatures. It included, but was not limited to, Policy.Temperatures of TCS (temperature controlled for safety) foods shall be recorded before being served from the steam table.Hot foods will be held at temperatures 135 degrees or above. This Citation relates to Intakes 2743395, 2749355, 2799515 and 2803955 410 IAC (Indiana Administrative Code) 16.2-3.1-21(a)(1)410 IAC 16.2-3.1-21(a)(2)

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Waters of Scottsburg, The	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 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. Based on observation, interview and record review, the facility failed to ensure a variety of snacks and snacks with nutritional value were available for the residents for 4 of 7 residents reviewed for dietary services. This deficient practice had the potential to affect 73 of 78 residents residing in the facility. Findings include:During an observation of the snack pantry on 3/15/26 at 11:00 a.m., the following was observed:-One jar of peanut butter on the counter next to the refrigerator-There was no bread in the pantry-A tray with 4 peanut butter sandwiches and 2 peanut butter and jelly sandwiches in baggies. The crust of the bread was hard. There were no other snacks observed in the pantry for the residents except what the residents had purchased for themselves. On 3/15/26 at 11:05 a.m., small bags of cheez-its were the only snacks observed on the snack cart. During an interview, on 3/16/26 at 10:35 a.m., Resident N indicated they don't have snacks all the time and sometimes don't get offered snacks at night because the staff do not have anything to give them. They had peanut butter and jelly sandwiches the other day and there was barely anything between the two slices of bread. When she pulled the bread apart, one side had a tan color, the other side purple color. It was spread so thin that the peanut butter and jelly had saturated into the bread, which was hard. There was no substance to the sandwiches. During an interview, on 3/16/26 at 11:40 a.m., Resident E indicated the only snacks available were peanut butter sandwiches on hard bread with barely any peanut butter on them. On 3/17/26 at 9:40 a.m., the following was observed of the snack sandwiches sent to the nutrition pantry from dietary for the residents with Staff Member 13: -On the snack tray were 6 peanut butter sandwiches and 2 peanut butter and jelly sandwiches in sandwich bags. The bread crust was hard on all the sandwiches.Staff Member 13 pulled apart the slices of bread of each sandwich, at that time, the peanut butter was so minimal that it saturated into the bread as well as the sandwiches with peanut butter and jelly. There was no substance to the sandwiches. Staff Member 13 indicated that dietary had sent down peanut butter sandwiches, on multiple occasions, with a small clump of peanut butter, no bigger than the size of a quarter, just placed in the middle of the bread and had not been spread. During an interview on 3/17/26 at 10:40 a.m., Resident O indicated the facility doesn't have snacks all the time and snacks don't get offered because they do not have anything to give us. During an interview, on 3/18/26 at 10:53 a.m., Resident S indicated the nursing staff had to go out and buy peanut butter and bread so the residents could have snacks to eat because the dietary department rarely sends any snacks out for the residents. On 3/15/26 at 3:00 p.m., the Executive Director provided a current, undated copy of the document titled Frequency of Meals. It included, but were not limited to, Policy.Each resident shall receive at least three (3) meals daily, as well as an evening or bedtime snack.Procedure.Between-meal snacks are available to those residents who request them. The policy, titled Between Meal Snacks included, but was not limited to, Policy.Between meal snacks are available for all.residents.Procedure.A variety of snacks of high nutritional value will be stocked in each service area by dining services. This Citation relates Intakes 2743395, 2749355, 2799515 and 2803955 410 IAC (Indiana Administrative Code) 16.2-3.1-21(e)

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Scottsburg, The	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure facial hair covering were in place for staff while working for 1 of 2 kitchen observations. Findings include:Upon entrance into the kitchen, on 3/15/26 at 12:14 p.m., signage on the kitchen door indicated staff must have hairnets in place and beard guards in place to enter the kitchen. During an observation on 3/15/26 at 12:16 p.m., Dietary Aide (DA) 6 and Dishwasher 7 both had 1/2 inch or longer facial hair on their lip and chin area. The DA 6 and Dishwasher 7 were observed in the kitchen dish and food prep areas without beard guards in place. During an interview, on 3/15/26 at 12:19 p.m., the Dietary Manager indicated they had just run out of the beard guards, however, it was the facility policy for beard guards to be in place while in the kitchen. On 3/15/26 at 3:00 p.m., the Executive Director provided a current copy of the document titled Proper Use of Hairnets and [NAME] Guards for Food Safety Compliance which was last reviewed on 6/2/25. It included, but was not limited to, Purpose .To ensure all personnel maintain proper hygiene and prevent contamination of food products .General Requirements .All personnel must wear approved .beard guards when in food preparation, processing, or storage areas .beard gaurds must be worn completely covering all .facial hair .beards and facial hair must be fully covered by the beard guard This Citation relates to Intakes 2743395, 2749355, 2799515 and 2803955 410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3)

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure the walls in the closet in a resident's (Resident B) room were clean and free of debris and failed to ensure the closet door was safely intact for 1 of 3 residents reviewed for environment. Findings include:The clinical record for Resident B was reviewed on 3/15/26 at 2:04 p.m. The resident's diagnosis included, but was not limited to, chronic obstructive pulmonary disease (a progressive chronic inflammatory lung disease that causes obstructed airflow, making it difficult to breath). On 3/17/26 at 10:20 a.m., the following observations were made in Resident B's room:-The sliding door to the closet was observed off the track and leaning up against the right side of the closet. Standing inside the closet looking out towards the room the right upper wall in the closet was observed with multiple gray/black spotted areas that extended across the width of the wall and extended 10 inches downward. The interior wall, above the closet entrance, had a large area, from top to bottom, of gray/black spotted areas. There were two gray/black streaked areas that filtered downward with a large dark gray/black area that measured 3 inches in length and 1.5 inches in width. During an interview, on 3/17/26 at 10:23 a.m., Staff Member 15 indicated the gray/black spotted areas were mold. Review of the deep cleaning schedule indicated the room was deep cleaned on 2/25/26. During an interview, on 3/18/26 at 10:18 a.m., the housekeeping supervisor indicated it was the responsibility of housekeeping to ensure closets are mopped, cleaned and free of debris and indicated the closet must have been missed during deep cleaning. This Citation relates to Intake 2730662. 410 IAC (Indiana Administrative Code) 16.2-3.1-19(f)