

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/14/2026
NAME OF PROVIDER OR SUPPLIER Waters of Scottsburg, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 physician ordered parameters were followed for 1 of 3 residents reviewed for quality of care (Resident C). Findings include: The clinical record for Resident C was reviewed on 7/14/26 at 9:55 a.m. The resident's diagnosis included, but was not limited to, hypertension (a condition where the force of blood against the artery walls is consistently too high, forcing the heart to work harder). The physician's order, dated 4/17/26, indicated the resident was to receive Coreg (medication for high blood pressure) 6.25 mg (milligrams) twice daily, in the morning and evening. The medication was to be held if the resident's systolic blood pressure (SBP) was less than 110. Review of the May 2026, June 2026 and July 2026 medication administration record indicated the resident received the medication on the following dates:- On 5/06/26, the resident received the evening dose with a SBP of 98.- On 5/14/26, the resident received the evening dose with a SBP of 108.- On 5/27/26, the resident received the morning dose with a SBP of 109.- On 6/08/26, the resident received the morning dose with a SBP of 109.- On 6/10/26, the resident received the evening dose with a SBP of 109.- On 6/15/26, the resident received the evening dose with a SBP of 107.- On 6/16/26, the resident received the morning dose with a SBP of 107.- On 6/24/26, the resident received the evening dose with a SBP of 103.- On 6/25/26, the resident received the morning dose with a SBP of 103.- On 7/04/26, the resident received the morning dose with a SBP of 98.- On 7/13/26, the resident received the morning dose with a SBP of 104. The physician's order, dated 4/17/26, indicated the resident was to receive Hydralazine (medication for high blood pressure) 50 mg three times a day, in the morning, afternoon and evening. The medication was to be held if the resident's systolic blood pressure was less than 110. Review of the May 2026, June 2026 and July 2026 medication administration record indicated the resident received the medication on the following dates:- On 5/06/26, the resident received the evening dose with a SBP of 98.- On 5/14/26, the resident received the afternoon dose with a SBP of 108.- On 5/14/26, the resident received the evening dose with a SBP of 108.- On 5/27/26, the resident received the morning dose with a SBP of 109.- On 5/28/26, the resident received the evening dose with a SBP of 101.- On 6/08/26, the resident received the morning dose with a SBP of 109.- On 6/10/26, the resident received the evening dose with a SBP of 109.- On 6/13/26, the resident received the morning dose with a SBP of 108.- On 6/15/26, the resident received the evening dose with a SBP of 107.- On 6/16/26, the resident received the morning dose with a SBP of 107.- On 6/24/26, the resident received the evening dose with a SBP of 103.- On 6/25/26, the resident received the morning dose with a SBP of 103.- On 6/28/26, the resident received the morning dose with a SBP of 102.- On 7/04/26, the resident received the morning dose with a SBP of 98.- On 7/13/26, the resident received the morning dose with a SBP of 104.- On 7/13/26, the resident received the afternoon dose with a SBP of 104. During an interview, on 7/14/26 at 11:44 a.m., Registered Nurse (RN) 4 indicated the physician set parameters should be followed. On 7/14/26 at 10:40 a.m., the Clinical Nurse Consultant (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
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Medications are administered in accordance with written orders of the attending physician. This Citation relates to Intake 3029909410 IAC (Indiana Authorization Code) 16.2-3.1-37		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 food temperatures were maintained for 1 of 1 lunch observation. Findings include: During a telephone interview, on 7/14/26 10:15 a.m., the complainant indicated the food was not warm when she received her meal trays. During an interview, on 7/14/26 at 10:22 a.m., Resident C indicated she received her meals in her room. Her food had not been warm when she received it. During an interview, on 7/14/26 at 10:29 a.m., Resident E indicated she ate all of her meals in her room and the food was cold when served. On 7/14/26 at 12:57 p.m., on the Eagle-[NAME] Hallway, the food temperatures, obtained by the outsourced Dietary Manager, were observed as follows: -Chile - 138.4 Farhenheit-Pureed Chile - 113.2 Farhenheit-Carrots - 125.2 Fahrenheit During an interview, on 7/14/26 at 1:00 p.m., the outsourced Dietary Manager indicated she did not understand how the food temperatures were not maintained at 135 degrees Fahrenheit. On 7/14/26 at 2:54 p.m., the Executive Director provided a current, undated copy of the document titled Food Temperatures at Point of Service. It included, but was not limited to, Food will be prepared, held, and served in a manner that preserves nutritive value and palatability .Procedure .Hot foods will be held at temperatures 135 degrees or above This Citation relates to Intake 3029909,410 IAC (Indiana Authorization Code) 16.2-3.1-21(a)(2)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure a resident's narcotic count sheet was available for review, failed to ensure administered narcotic pain medication was documented on the medication administration record, and failed to ensure insulin administration was documented timely for 2 of 3 residents reviewed for Resident Records. (Resident B and Resident C) Findings include: 1. The clinical record for Resident B was reviewed on 7/14/26 at 8:44 a.m. The resident's diagnoses included, but were not limited to, diabetes (a chronic condition where the body cannot process blood sugar properly) and depression (a common, serious mood disorder that causes persistent feelings of sadness, emptiness, and loss of interest in activities). The physician's order, dated 4/17/26, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 5-325 mg (milligrams) every 6 hours as needed for pain. The pharmacy packaging slip, dated 4/20/26, indicated the facility received 30 tablets of the Hydrocodone-Acetaminophen 5-325 mg for the resident. The clinical record lacked documentation of a controlled drug record for the narcotic pain medication delivered on 4/20/26 for administrations between 4/23/26 through 5/8/26. During an interview, on 7/14/26 at 2:04 p.m., the Director of Nursing indicated they could not locate the controlled drug record. Review of the controlled drug record for April 2026 and May 2026 indicated the medication was administered on the following dates and times: 4/17/26 at 8:00 p.m., 4/18/26 at 8:00 p.m., 4/19/26 at 8:00 p.m., 4/20/26 at 8:00 p.m., 4/21/26 at 6:00 a.m. and 8:00 p.m., 4/22/26 at 8:00 p.m., 5/09/26 at 8:00 p.m., 5/11/26 at 8:00 p.m., 5/12/26 at 8:00 p.m., 5/14/26 at 6:30 p.m., 5/15/26 at 12:00 a.m. and 7:00 p.m., 5/16/26 at 8:00 p.m., 5/17/26 at 7:30 p.m., and 5/19/26 at 7:00 p.m. The April 2026 and May 2026 medication administration record lacked documentation of the administration of the narcotic pain medication on the above dates. The physician's order, dated 5/10/26, indicated the resident was to receive Humalog (slow-acting insulin), 8 units subcutaneously with meals at 7:00 a.m., 11:00 a.m. and 5:00 p.m. The May 2026 medication administration record indicated the insulin was administered on the following dates and times: - On 5/11/26, 7:00 a.m. scheduled dose administered at 10:14 a.m. - On 5/13/26, 7:00 a.m. scheduled dose administered at 10:21 a.m. - On 5/14/26, 7:00 a.m. scheduled dose administered at 10:08 a.m. - On 5/14/26, 11:00 a.m. scheduled dose administered at 12:48 p.m. - On 5/15/26, 7:00 a.m. scheduled dose administered at 8:32 a.m. - On 5/16/26, 7:00 a.m. scheduled dose administered at 8:41 a.m. - On 5/17/26, 7:00 a.m. scheduled dose administered at 8:38 a.m. - On 5/17/26, 11:00 a.m. scheduled dose administered at 12:31 p.m. - On 5/18/26, 7:00 a.m. scheduled dose administered at 10:40 a.m. - On 5/18/26, 11:00 a.m. scheduled dose administered at 12:28 p.m. - On 5/19/26, 7:00 a.m. scheduled dose administered at 11:37 a.m. - On 5/19/26, 11:00 a.m. scheduled dose administered at 3:12 p.m. - On 5/20/26, 7:00 a.m. scheduled dose administered at 12:22 p.m. - On 5/20/26, 11:00 a.m. scheduled dose administered at 12:49 p.m. - On 5/21/26, 7:00 a.m. scheduled dose administered at 9:11 a.m. - On 5/22/26, 7:00 a.m. scheduled dose administered at 10:08 a.m. During an interview, on 7/14/26 at 11:44 a.m., Registered Nurse (RN) 4 indicated medications with a scheduled time should be administered an hour before or an hour after the scheduled time and documented at that time. On 7/14/26 at 2:42 p.m., the Regional Nurse Consultant provided a current copy of the document titled Confidentiality of Medical Records dated 6/26/23. It included, but was not limited to, Policy. It is the facilities responsibility for safeguarding both the resident's medical record and its information against loss. On 7/14/26 at 10:40 a.m., the Clinical Nurse Consultant 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 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered as prescribed.Procedure.Medications are administered in accordance with written orders of the attending physician.Medications are administered within 60 minutes of scheduled time.The resident's MAR is initialed by the person administering a medication. 2. The clinical record for Resident C was reviewed on 7/14/26 at 9:55 a.m. The resident's diagnoses included, but were not limited to, fibromyalgia (chronic disorder characterized by widespread musculoskeletal pain) and depression (a common, serious mood disorder that causes persistent feelings of sadness, emptiness, and loss of interest in activities).The physician's order, dated 5/14/26, indicated the resident was to receive Hydrocodone-Acetaminophen 10-325 mg every 6 hours as needed for pain.Review of the May 2026, June 2026 and July 2026 controlled drug records indicated the resident received the pain medication on the follow dates and times: 5/16/26 at 6:00 p.m., 5/18/26 at 12:00 a.m., 5/19/26 at 12:00 a.m., 5/20/26 at 12:00 a.m., 5/22/26 at 8:00 p.m., 5/23/26 at 8:00 p.m., 5/24/26 at 8:00 p.m., 5/25/26 at 8:00 p.m., 5/28/26 at 7:00 p.m., 5/29/26 at 12:00 a.m., 5/29/26 at 7:00 p.m., 6/01/26 at 7:30 p.m., 6/02/26 at 12:30 a.m., 6/02/26 at 8:00 p.m., 6/03/26 at 8:00 p.m., 6/04/26 at 8:30 p.m., 6/07/26 at 5:45 p.m., 6/08/26 at 8:00 p.m., 6/09/26 at 7:30 p.m., 6/10/26 at 8:00 p.m., 6/11/26 at 11:00 p.m., 6/15/26 at 7:00 p.m., 6/15/26 at 11:00 p.m., 6/16/26 at 8:00 p.m., 6/17/26 at 8:00 p.m., 6/18/26 at 11:00 p.m., 6/20/26 at 1:45 a.m., 6/22/26 at 6:30 p.m., 6/23/26 at 7:00 p.m., 6/24/26 at 7:00 p.m., 6/25/26 at 8:00 p.m., 6/28/26 at 7:26 p.m., 6/29/26 at 9:00 a.m., 7/01/26 at 9:00 p.m., 7/02/26 at 9:00 p.m., 7/06/26 at 7:30 p.m., 7/09/26 at 7:00 p.m., 7/10/26 at 7:00 p.m., and 7/11/26 at 12:00 a.m. The resident's May 2026, June 2026 and July 2026 medication administration record lacked documentation of the above administrations. This Citation relates to Intake 3029909,410 IAC (Indiana Authorization Code) 16.2-3.1-50(a)(1)410 IAC (Indiana Authorization Code) 16.2-3.1-50(a)(2)		