

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 04/13/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interviews, and record review, the facility failed to ensure food was stored and prepared in a sanitary manner during 3 of 3 kitchen observations. This deficient practice had the potential to affect 63 or 63 residents. Findings include: During the initial tour of the kitchen, on 4/7/26 at 10:23 a.m., while accompanied by the Dietary Manager, the following concerns were observed:-The left-side metal table near the dishwasher in the dish room had a large accumulation of brown water with egg particles floating in the water.-The outside of three glass coffee decanters sitting on the coffee pot bases were covered with a white sticky film.-The floor had a dried sticky spill in front of the long metal prepping table.-The floor had a dried sticky spill at the entrance to the kitchen. -The stovetop burners had a heavy accumulation of black crust on them.-There was a large accumulation of debris and dust underneath the food storage shelving in the dry storage room.-The walk-in freezer had a condenser pipe wrapped in a foam tube and covered with black tape. There was a silver bucket sitting on a shelf on top of a cookie sheet to collect water if it began leaking. The bucket had a small amount of water in it. On the lower shelf below, there was an opened box of single yogurts, a box of frozen chicken meat, and a box of Salisbury steak meat.During an interview, 4/7/26 at 10:25 a.m., the Dietary Manager indicated the pipe in the walk-in free would freeze at times and the bucket was to collect leaking water. He indicated that maintenance was aware of the occasional leaking.During an observation, 4/7/26 at 11:35 a.m., the Robot Coupe (used to create smooth purees, sauces, and baby food) was used to puree beef stroganoff, broccoli, and rolls. The lid was cracked in one area from the edge to the center of the lid. 2. During the second observation of the kitchen, while accompanied by the Dietary Manager, on 4/9/26 at 1:00 p.m., the following concerns were identified:-The same issues identified on 4/7/26 at 10:23 a.m., remained a concern except for the standing brown water with egg particles on the metal table in the dish room.-There was a large accumulation of breadcrumbs on the prepping table, near the toaster and on the floor.During an interview with the Administrator and Maintenance, on 4/8/26 at 10:37 a.m., the Maintenance Director indicated that he had been letting the kitchen verbally tell him if the pipe was leaking. He would put a new work order into the electronic system for repairs. He was waiting for defrost mode to work on the pipe.During an interview with the Dietary Manager, on 4/9/26 at 1:00 p.m., he was unsure when the lid cracked on the Robot Coupe, but did verbalize that it was after he started working at the facility a year ago. The Dietary Manager indicated at this time that Maintenance had fixed the condenser pipe in the walk-in freezer.During an interview, on 4/9/26 at 1:30 p.m., the Administrator indicated that on 4/8/26 a lid was purchased for the Robot Coupe. The administrator indicated that a work order had been placed on 4/8/26 for Maintenance to repair the condenser pipe in the walk-in freezer. She indicated the freezer was original to the building with older parts to repair.During an interview with the Dietary Manager, on 4/10/26 at 9:05 a.m., he indicated on 4/9/26 the steam table looked dirty to him due to a staff member resigning the previous evening who would have cleaned it.During a record review of the daily cleaning schedule, on 4/9/26 at 2:00 p.m., the document indicated many kitchen tasks were to be completed daily. The following tasks were completed and initialed on 4/6/26, 4/7/26, and 4/8/26. -Mopping and sweeping kitchen-Toaster cleaned.-Steam tables drained and wiped out at the end of (continued on next page)</p>		

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 04/13/2026
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>the day-Dry storage area organized and swept-Stovetop/range/grill cleaned and scrubbed at the end of the day. 3. During the third observation of the kitchen, while accompanied by the Dietary Manager, on 4/13/26 at 9:00 a.m., the following was identified: continued use of the Robot Coupe until it would be replaced. The condenser pipe in the walk-in freezer remained intact with the foam tube and heat tape. The was no bucket to catch potential leaking water. The current policy, titled Sanitation was provided by the Administrator on 4/9/26. The policy indicated, but was not limited to, .The food service area shall be maintained in a clean and sanitary manner. 1. All kitchens, kitchen areas, and dining areas shall be kept clean. 2. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas. 410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3)</p>		

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 04/13/2026
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments accurately reflected the residents' medication status for 1 of 21 resident MDS reviewed for accuracy of assessments. (Resident 10). Findings include: The record for Resident 10 was reviewed on 4/7/26 at 1:14 p.m. The diagnosis included, but was not limited to, moderate depressive disorder, recurrent (a serious, common mental health condition characterized by persistent sadness, loss of interest in activities and low energy which lasted at least 2 weeks). The Quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident had slight impairment in cognition, frequently felt down or depressed and felt tired. The MDS, medication section, indicated the resident was marked as not having used any anti-depressants. A physician's order, dated 11/24/25, indicated the resident was to take 1 tablet of mirtazapine (Remeron - anti-depressant medication) tablet 15 milligrams (mg) at bedtime for depression. An interview with the MDS Coordinator, on 4/13/26 at 10:30 a.m., she indicated that if she had not already transmitted the information, then she would go back and correct the areas needed. If the MDS was already transmitted, then she would complete a correction MDS. On 4/10/26 at 2:15 p.m., the Executive Director indicated there was no specific policy on MDS coding, but the MDS coding followed the Resident Assessment Instrument (RAI) instructions. 410 IAC (Indiana Administrative Code) 16.2-3.1-31(h) 410 IAC 16.2-3.1-31(i)</p>		

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 04/13/2026
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, record review, and interview, the facility failed to ensure documentation on the Controlled Drug Receipt/Record/Disposition Form of administered narcotics for 2 of 46 residents observed for pharmacy services. (Residents 7 and 68) Findings include: 1. During an observation, on 4/9/26 at 10:25 a.m., the Controlled Drug Receipt/Record/Disposition Form indicated Resident 7's Pregabalin (used to treat anxiety and neuropathic pain) was documented as administered on 4/9/26 at 8:00 a.m., by Licensed Practical Nurse (LPN) 4. The count on the sheet indicated 25 capsules left. The medication card indicated 26 capsules left. During an interview, on 4/9/26 at 10:28 a.m., LPN 4 indicated she thought she had administered the medication that morning. She could not explain why the count was off. At 10:48 a.m., LPN 4 indicated the administration range of Resident 7's Pregabalin was between 7:00 a.m. and 11:00 a.m., and she had not administered the medication, so she wasn't late to administer it. She then indicated she should not have signed the narcotic out before administering it, because the count would be off. The record for Resident 7 was reviewed on 4/9/26 at 2:47 p.m. The diagnosis included, but was not limited to, neuralgia (severe, sharp stabbing or burning pain) and neuritis (swelling of nerves causing numbness or muscle weakness). The physician's order, dated 7/29/25 at 7:00 a.m., indicated the nurse was to administer 300 milligrams (MG) of Pregabalin to the resident, two times a day for neuropathy between 7:00 a.m. and 11:00 a.m. The care plan, dated 12/16/25 and last revised 2/23/26, indicated the resident was at risk for adverse effects related to opioid medication use for pain management. The interventions, dated 12/16/25, included, but were not limited to, administer medications as ordered, monitor vital signs as needed, particularly respirations, and observe for effectiveness of medications. The April 2026 Medication Administration Record (MAR) indicated the nurse was to administer 300 milligrams (MG) of Pregabalin to the resident, two times a day for neuropathy between 7:00 a.m. and 11:00 a.m. 2. During an observation, on 4/9/26 at 10:58 a.m., the Controlled Drug Receipt/Record/Disposition Form indicated Resident 68's Hydrocodone-Acetaminophen (Norco) had a count of 11 tablets documented. There were 10 tablets left on the medication card. The 5-325 mg Norco was documented as last administered by LPN 5 on 4/8/26 at 8:00 p.m. During an interview, on 4/9/26 at 11:00 a.m., LPN 6 indicated she forgot to sign out the Norco. She got distracted by another resident. She should sign out narcotics when she administered them. The record for Resident 68 was reviewed on 4/10/26 at 11:00 a.m. The diagnosis included, but was not limited to, chronic pain syndrome (pain lasting longer than 3 to 6 months with emotional or functional issues). The care plan, dated 1/14/26, indicated the resident had a diagnosis of chronic pain syndrome and was at increased risk for alteration in pain or discomfort and was at risk for adverse effects from opioid drug use. The interventions, dated 1/14/26, included, but were not limited to, medications per order, to notify the physician for any new complaints of pain, monitor for signs or symptoms of pain to obtain new order for medication regimen or break-through pain management, and observe for effectiveness of pain relief. The physician's order, dated 2/11/26 at 8:00 p.m., indicated the nurse was to administer 5-325 mg of Hydrocodone-Acetaminophen (Norco) two times a day for pain. The April 2026 MAR, indicated the resident received 5-325 mg Norco on 4/8/26 at 8:00 p.m. by LPN 5. The current Guidelines for Controlled Substance Medications - An overview policy, included, but was not limited to, . Responsibilities of the Nurse Who Receives/Takes Possession of/Accepts-Delivered Controlled Drugs. Verify drug strength and number received. Sign the Controlled Medication Delivery Manifest, verifying receipt of the medication (both quantity and strength). 410 IAC (Indiana Administrative Code) 16.2-3.1-25(b)(1)(c)</p>		

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 04/13/2026
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review, and interview, the facility failed to ensure glucometers were cleaned per guidelines for infection control when obtaining blood sugar readings for 2 of 3 residents observed. (Residents 29 and 7) Findings include: 1. During an observation, on 4/9/26 at 8:05 a.m., Resident, 29's accu check (glucometer - machine used for blood sugar monitoring) was completed by Licensed Practical Nurse (LPN) 4. The resident's blood sugar was 254 milligrams per deciliter (mg/dL). The LPN brought the glucometer back to the medication cart and placed it into the resident's case without cleaning it. LPN 4 obtained the insulin and administered it to the resident. She then went onto her computer to check off the medication and went on to her next resident. The record for Resident 29 was reviewed on 4/10/26 at 10:09 a.m. The resident's diagnosis included, but was not limited to, type 2 diabetes mellitus (high blood sugar) with diabetic neuropathy (nerve damage caused by long-term high blood sugar). The physician's order, dated 11/11/25, indicated staff were to perform accu checks two times a day for type 2 diabetes mellitus. 2. During an observation, on 4/10/26 at 9:01 a.m., Resident 7's blood sugar was obtained from the right index finger by LPN 4. The resident's blood sugar reading was 215 mg/dL. The resident required sliding scale Humalog. The LPN placed the glucometer in the resident's glucometer case without cleaning it. The LPN then administered the Humalog required. The record for Resident 7 was reviewed on 4/9/26 at 2:47 p.m. The resident's diagnosis included, but was not limited to, type 2 diabetes mellitus. The physician's order, dated 4/1/26 at 7:00 p.m., indicated staff were to monitor the resident's blood sugar for visible signs or symptoms of hypoglycemia or hyperglycemia. If symptoms are apparent, check the blood sugar and follow the prn blood sugar flowchart. During an interview, on 4/10/26 at 9:06 a.m., LPN 4 indicated if the glucometer was shared with other residents, they were cleaned after each use. But the glucometer that was stored individually in the cases, would not need to be cleaned. The shared glucometer would be cleaned after each resident, to prevent germs from being passed on to another resident. She should wrap the glucometer in the Sani-Cloth (Wipes were used by the facility to disinfect high risk areas) for 2 minutes. She was unsure how long to let the glucometer dry after that. The LPN indicated she could not find any Sani-wipes in her cart or in storage. During an interview, on 4/10/26 at 9:13 a.m., the Director of Nursing (DON) indicated the glucometer should be cleaned after every use even if they were used only for one resident. They should be cleaned to prevent bacteria for infection control. The Sani-Cloth containers were readily available in the storage room. She indicated she knew who had not been cleaning the glucometers after each use. The current Cleaning/Disinfecting/Maintaining Glucose Meters policy included, but was not limited to, The Glucose meters will be disinfected between each resident use to prevent the spread of microorganisms including blood borne pathogens. Disinfection of the machine will be completed with PDI Super Sani Germicidal wipes or Bleach Wipes as per guidelines of the manufacturer of the glucometer. Two disposable wipes will be needed for each cleaning and disinfecting procedure; one wipe for cleaning and the second wipe for disinfecting. Note: always create a dry 'barrier' between the meter and any surface on which it is placed during actual use or cleaning. Paper towels are commonly used. Procedure: Cleaning and Disinfecting 4. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using one towelette to clean blood and other body fluids. 5. Dispose of the towelette. 6. Obtain a second towelette and wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood borne pathogens. The meter must be maintained wet for 2 minutes with the Super Sani cloth wipe. 7. Once the exterior of the glucose meter has remained wet for the appropriate contact time, the meter may be wiped dry with a dry cloth. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)(2)</p>		

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 04/13/2026
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)		
<p>F 0576</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>Based on interview, the facility failed to ensure Saturday's mail was delivered to the residents upon arrival to the post box. This deficient practice had the potential to affect 63 of 63 residents currently residing in the facility. Findings include: During the Resident Council meeting, on 4/10/26 at 10:00 a.m., with 6 residents who were alert and oriented per the Assistant Activity Director, the residents indicated they were not getting their Saturday mail as no Activity Staff was there on the weekends. They were the ones who usually passed it out. The residents indicated they had seen the mail be delivered to the outside mail box but no one went and got it. During an interview with the Activities Director, on 4/13/26 at 12:45 p.m., she indicated there was no one assigned to pass the mail on Saturdays. Human Resources would retrieve it first thing Monday morning from the mail box, sort through the bills and other important mail she needed to address and then bring the rest of the residents' mail to her to pass out. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(s)(1)</p>		