STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Tipton Skilled Nursing Facility, The	300 Fairgrounds Rd Tipton, IN 46072

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. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure residents were treated with respect and dignity for 2 of 4 residents reviewed for dignity. (Resident B and C)Findings include:1. During an observation, on 11/11/25 at 3:12 p.m., Resident B had a healed scar from a laceration above her right eyebrow.The clinical record for Resident B was reviewed on 11/11/25 at 10:25 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, generalized anxiety disorder, mood disorder, cognitive communication deficit, major depressive disorder, altered mental status, and dementia.A quarterly minimum data set (MDS) assessment, dated 8/10/25, indicated Resident B had a severe cognitive impairment. The resident required maximal assistance to maintain personal hygiene which included combing hair, shaving, applying makeup, and washing/drying face and hands.A care plan, dated 10/13/25, indicated the resident was at risk of psychosocial distress. Interventions included, but were not limited to, offer reassurance she was safe in the facility.In a facility witness statement, dated 11/3/25, LPN 7 indicated QMA 2 came into the facility, on 11/3/25, and indicated she needed to report something which happened the day before, but she did not know who to tell. LPN 7 told QMA 2 to tell her what happened and she would help direct her. QMA 2 indicated QMA 1 had sprayed Resident B's face with wound cleanser and then marked her forehead with a L. The Executive Director (ED) and Director of Nursing (DON) arrived at the nurse's station and took over the investigation.In a facility witness statement, dated 11/3/25, QMA 2 indicated Resident B was at the nurse's station with LPN 3, CNA 4, and CNA 5. QMA 1 was outside of the nurse's station acting like she was going to spray everyone with a bottle of wound cleanser. QMA 1 sprayed Resident B's hair, and the liquid ran down the resident's face. CNA 4 wiped the resident's face off. QMA 1 then took a marker and scribbled on the resident's forehead. CNA 5 removed the mark from the resident's forehead. The incident happened around 1:00 p.m., on 11/2/25.In a facility witness statement, dated 11/3/25, QMA 1 indicated she had sprayed another staff member with wound cleanser at the nurse's station, on 11/2/25, and it had also gotten on Resident B's face. QMA 1 then placed a mark with a purple/blue colored marker on the resident's forehead. She then wiped it off with wet wipes.In a facility witness statement, dated 11/3/25, CNA 5 indicated she, QMA 1, and CNA 4 were all in the nurse's station, on 11/2/25. QMA 1 sprayed Resident B with wound cleanser on the forehead and another staff member wiped it off. QMA 1 then put a purple/blue mark on the resident's forehead. CNA 5 indicated she wiped the marker off using water a wipe. In a facility witness statement, dated 11/3/25, CNA 4 indicated she had Resident B at the nurse's station while she charted, on 11/2/25. QMA 1 grabbed the water bottle with a pink cap on it and sprayed the resident's hair. CNA 4 then brushed the resident's hair out at the nurse's station. QMA 1 took a purple/blue marker and put a dot on resident's forehead but then washed it off with a wet wipe. CNA 5 was also at the nurse's station.During an interview, on 11/11/25 at 10:00 a.m., the Executive Director (ED) indicated the facility conducted a thorough investigation of the incident with QMA 1 and Resident B. The resident had no signs of distress. She had contacted the police and filed a notice against QMA 1 with the attorney general's office. The investigation revealed QMA 1 sprayed the resident's hair and forehead and then used a marker on the resident's forehead at the nurse's station, on 11/2/25. This was unacceptable behavior and would not be tolerated by the facility. 2. During an observation, on 11/12/25 at 10:00 a.m., Resident C was resting in his room and had a full beard and mustache.The clinical record for Resident C was reviewed on 11/10/25 at 2:50 p.m. The diagnoses included, but were not limited to, Parkinson's disease, type 2 diabetes mellitus, dementia with agitation, cognitive communication deficit, Alzheimer's disease, depression, and dysphagia.A quarterly MDS assessment, dated 8/25/25, indicated Resident C had severe cognitive impairment.A facility profile picture of Resident C in the electronic medical record showed the resident with a beard and mustache.In a facility witness statement, dated 11/4/25 at 1:49 p.m., CNA 8 indicated she worked on 8/29/25 from 2:00-6:00 p.m. QMA 1 was in the dining room laughing and asked her how Resident C looked without eyebrows. CNA 8 asked QMA 1 what had happened and QMA 1 indicated she had shaved them off. CNA 8 asked QMA 1 if his Power of Attorney (POA) was going to be upset and QMA 1 indicated his POA never came to the facility. CNA 8 notified RN 9. RN 9 asked Resident C if he had given permission to have his beard and eyebrows shaved and he said no. RN 9 indicated she would tell the DON.In a facility witness statement, dated 11/6/25, CNA 5 indicated she had not worked the day the resident's eyebrows and face were shaved, but when she came to work the next day, the resident's eyebrows and facial hair were all shaved off. LPN 7 indicated to CNA 5 that the resident had been done dirty. The staff routinely used an electric razor to trim and shave