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	03/26/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure a resident remained safe from accident hazards during incontinence care provided by a staff member for 1 of 8 residents reviewed for accidents. This deficient practice resulted in Resident 63 hitting her head and receiving a head laceration which required six (6) staples.Findings include:The clinical record for Resident 63 was reviewed on 3/23/26 at 8:52 a.m. The diagnoses included, but were not limited to, muscle weakness, Alzheimer's disease, dementia, and muscle wasting and atrophy.A care plan, dated 11/18/25, indicated the resident required assistance with activities of daily living. Interventions included, but were not limited to, ensure proper positioning while in bed.A Minimum Data Set (MDS) assessment, dated 1/28/26, indicated Resident 63 required substantial to maximal assistance to roll from back to side and to return to the back while in bed.A progress note, dated 2/13/26 at 1:10 p.m., indicated a CNA was completing care on Resident 63, rolled the resident toward the wall, bumped the resident's head on the trim of the wall, and caused a laceration to the top of her head.A facility document, titled Skin Integrity Issue-Other than Pressure Ulcer, dated 2/13/26 at 2:10 p.m., indicated while placing the resident back into a low air loss (LAL) mattress with bolsters to perform incontinent ADL care, a staff member placed the resident on her back on the inflated mattress with the bed raised to waist height of the staff member. They started to roll the resident to the right side and bumped her head on the chair railing on the wall which resulted in a laceration to the top of her head.An emergency room physician's note, dated 2/13/26, indicated according to the resident's facility, while the resident was being moved in her bed today, the top of her head hit part of the bed frame. This caused a laceration on the top of her scalp, and she was sent for evaluation and treatment. A laceration repair was performed to a 4.5 cm wound. The wound was reapproximated by utilizing 6 staples.A facility confidential witness statement, signed on 2/13/26 by Licensed Practical Nurse (LPN) 12, indicated she was told by CNA 11, the CNA rolled the resident over in bed to do care, accidentally hit the top of the resident's head on the wall trim, and caused the resident's head to bleed.A facility confidential witness statement, signed on 2/13/26 by CNA 11, indicated CNA 11 placed Resident 63 into bed on her LAL mattress. When she went to change the resident, she rolled the resident towards the wall. While rolling Resident 63, she clipped her head on the wooden strip on the wall.During an interview, on 3/24/26 at 12:07 p.m., the Director of Nursing (DON) indicated CNA 11 had raised the bed to waist height to perform care for the resident. The incident occurred during care. The CNA rolled the resident over too far and the resident's head was hit on the trim of the wall. It was a combination of the LAL mattress being inflated and the CNA rolling over the resident too far which caused the resident's head to hit the trim on the wall.During an interview, on 3/24/26 at 12:07 p.m., the Executive Director (ED) indicated it was a combination of the LAL mattress being inflated and CNA 11 rolled the resident over too far which caused the resident's head to hit the trim on the wall.During an interview, on 3/25/26 at 9:38 a.m., CNA 11 indicated her and another CNA transfered Resident 63 into bed. After transferring the resident into the bed, she then alone performed a brief change for the resident. It was a combination of her rolling the resident too far over and the bed was inflated which caused the resident to roll over even more. Her head was hit on the trim on the wall. Resident 63 cannot roll on (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	her own and needed help from staff to roll over.During an interview, on 3/26/26 at 3:39 p.m., the DON indicated the facility followed all federal and state regulations.During the exit conference, on 3/26/26 at 4:23 p.m., the DON indicated the facility had no additional information to submit for review related to the accident.This citation relates to Intake 2744045.410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(2)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and record review, the facility failed to ensure a resident's nutritional status was assessed, risk factors were identified and addressed, interventions were implemented, and the physician was notified of the need to assess a significant weight loss for 1 of 3 residents reviewed for nutrition. (Resident 7) This deficient practice resulted in Resident 7 experiencing an approximate 22% weight loss in approximately 4 months. Findings include:During an observation, on 3/19/26 at 12:26 p.m., Resident 7 was not eating her lunch. The CNA charting indicated the resident refused her lunch. No replacement meal or alternatives offered were charted for her lunch, on 3/19/26.During an observation, on 3/20/26 at 12:37 p.m., Resident 7 ate less than half her lunch.The clinical record for Resident 7 was reviewed on 3/24/26 at 9:45 a.m. The diagnoses included, but were not limited to, dementia, major depressive disorder, muscle weakness, muscle wasting and atrophy of the right and left arms, and cognitive communication deficit.A hospital discharge document, dated 11/18/25, indicated Resident 7's current ongoing problems included weight loss and malnutrition and the most recent weight in the last 24 hours was 181 lbs. A care plan, dated 11/21/26, indicated Resident 7 was at risk of malnutrition. Interventions included, but were not limited to, monitor weights as ordered and refer to the Registered Dietician as needed for significant weight loss or observed poor intake.A physician's order, dated 11/18/25, indicated Resident 7 could receive a general diet with regular texture and thin liquids.The facility weight log indicated, on 11/18/25, Resident 7 weighed 180.6 pounds.An admission Minimum Data Set (MDS) assessment, dated 11/21/25, indicated Resident 7 weighed 181 pounds and had no weight loss.A physician's order, dated 12/7/25, indicated to obtain weekly weights for four (4) weeks every dayshift on Sunday for SWAT (skin wound observation team) monitoring.The facility weight log indicated, on 12/8/25, Resident 7 weighed 160 pounds which was a 11.41% weight loss. The admission weight of 180.6 pounds was cancelled as a data entry error by the dietician, on 12/9/25, with no progress note to indicate why the weight was considered invalid and was cancelled.There was no documentation the physician or facility interdisciplinary team was notified of the weight change. A skilled nursing progress note, dated 12/8/25 at 9:25 a.m., indicated the resident weighed 160 pounds.A physician's progress note, dated 12/14/25, indicated Resident 7's weight was 180.6 pounds. There was no indication of concerns or notification of the weight loss documented.A dietician's recommendation report, dated December 2025, indicated the recommendation was to add house shakes three times a day for weight stability.The electronic medical record did not include an order for house shakes in December or January.A review of Resident 7's meal intakes, for December 2025, indicated the resident had refused or eaten less than half of her meal for 14 meals and had eaten 51-75% of her meal for 26 meals in December.A weight summary indicated, on 1/4/26, Resident 7 weighed 149.3 pounds which was a 6.69% weight loss from the 160-pound weight documented on 12/8/25.A skilled nursing progress note, dated 1/4/26 at 9:33 a.m., indicated Resident 7 was fed that morning due to not attempting to feed herself.A physician's progress note, dated 1/6/26 at 8:53 a.m., indicated the physician was new to the resident and had just taken over her care. Her weight was listed at 149.3 pounds. There was no documentation on prior weights or the resident's weight loss.A skilled nursing progress note, dated 1/7/26 at 9:42 a.m., indicated Resident 7's weight was 149.3 pounds. She required verbal cueing at the minimum and was fed that morning due to not attempting to feed herself.A weight log, dated 1/11/26, indicated Resident 7 weighed 146.4 pounds which was an 8.5% loss in a month from the 160 pounds on 12/8/25. A dietary progress note, dated 1/26/26 at 2:06 p.m., indicated Resident 7's weight was 147.5 pounds with a declining weight trend and an 8.9% weight loss with stalled wound healing. The dietician recommended adding house shakes twice a day to enhance intakes. An order for supplemental house shakes was not initiated until 2/18/26.The dietician's weekly nutrition at risk report, dated January 2026, did not have Resident 7 included on the list of residents with weight loss.A review of Resident 7's meal intakes, for January 2026, indicated the resident had refused or (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	eaten less than half of her meal for 28 meals and had eaten 51-75% of her meal for 25 meals in January.A weight record, dated 2/15/26, indicated Resident 7 weighed 143.9 pounds which was a 10.06% weight loss in less than 3 months from the 160 pounds, on 12/8/25.A physician's order, dated 2/18/26, indicated to administer a house shake two times a day for weight stability.A quarterly nutritional risk review, dated 2/18/26 at 10:58 a.m., indicated Resident 7's weight was 143 pounds and there was no weight loss of more than 5% in the last month or a loss of 10% or more in the last 6 months with no issues noted and no referral to the dietician had been performed.A quarterly MDS assessment, dated 2/21/26, indicated Resident 7 weighed 144 pounds which was a significant weight loss while not being on a prescribed weight-loss regimen.A physician's progress note, dated 3/17/26 at 10:05 a.m., did not indicate the facility had notified the physician or Resident 7 was assessed for a significant weight loss.A weight summary, dated 3/23/26, indicated Resident 7's current weight was 140.7 pounds.The documented 181-pound weight, on 11/18/25, and the documented 140.7-pound weight, on 3/23/26, would be an approximate 22% weight loss in approximately 4 months and 5 days. A review of Resident 7's meal intakes, for March 2026, indicated the resident had refused or eaten less than half of her meal for 14 meals and had eaten 51-75% of her meal for 23 meals so far in March.During an interview, on 3/25/26 at 2:45 p.m., LPN 5 indicated Resident 7 needed cueing and encouragement to eat most of the time. Resident 7 did not have any weight loss concerns being monitored by nursing.During an interview, on 3/26/26 at 10:47 a.m., the Director of Nursing (DON) indicated Resident 7 was admitted after having sepsis in the hospital where she had been given a lot of fluids and diuretics, so the facility had expected some weight loss. The facility was not following her for weight loss even after weight loss had continued for months after her hospital discharge and no longer receiving any diuretics.The DON did not provide any documentation or indication the facility was monitoring Resident 7 for weight loss, or the physician had been notified and was evaluating the resident.During an interview, on 3/26/26 at 1:49 p.m., the Assistant Director of Nursing (ADON) indicated she had initiated the house shakes for nutrition in February.A current facility policy, titled GUIDELINES FOR OBTAINING RESIDENTS' WEIGHTS, dated 7/24/24 and provided by the DON on 3/26/26 at 9:40 a.m., indicated .changes in weight can often indicate other medical changes.Compare the obtained to the previous weight. If there is a significant variance.be sure to reweigh the resident to verify the weight. If a weight is found to be incorrect - note this and initial the error - then notify the nurse for guidance.A current facility policy, titled S-W-A-T PROGRAM (SKIN AND WEIGHT ASSESSMENT TEAM) WEIGHT MANAGEMENT, dated 10/9/23 and provided by the ADON on 3/26/26 at 1:45 p.m., indicated .assess the.medication with side effect.dx of severe dementia.s/s of depression.s/s constipation.calorie count.diet acceptance.recent notifications made to MD, RD, Family.410 IAC (Indiana Administrative Code) 16.2-3.1-46(a)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-46(a)(2)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure puree foods were prepared with methods to conserve nutritive value and flavor and to maintain proper food holding temperatures to ensure safe and appetizing temperatures. This deficient practice had the potential to affect 93 of 93 residents who received food from the facility.Findings include:1. During an observation, on 3/20/26 at 9:54 a.m., [NAME] 2 was pureeing beef pot roast and carrots for seven residents who required a puree diet. [NAME] 2 placed two large scoops of the beef pot roast and an unmeasured amount of hot water into the food processor bowl and turned it on. [NAME] 2 turned the food processor off to check the consistency of the pureed food and determined the beef pot roast was still too thick. [NAME] 2 again added an unmeasured amount of hot water into the food processor and turned it back on to continue to puree the meat. When [NAME] 2 believed the pureed beef pot roast was at an appropriate texture, the food was removed from the food processor bowl and a small scoop of juices from the main roasting pan was added to the pureed portion.During an interview, on 3/20/26 at 10:03 a.m., the Dietary Manager (DM) indicated staff used water as a thinning agent during the pureeing process but would add a small amount of juice from the main cooking pan after the process was complete. She indicated the facility had recipes for all meals the kitchen prepared.A review of the kitchen recipe for beef pot roast indicated to count/measure out the number of portions needed. The food was to be added into the food processor and processed to a smooth consistency by adding juice, milk or broth, whichever was most appropriate for the item being pureed as needed to achieve desired consistency.Cook 2 was not observed utilizing or following the recipe or its instructions.2. During an interview, on 3/19/26 at 10:44 a.m., Resident 12 indicated she ate in the dining room on the second floor and meals were not always hot when served.During an interview, on 3/24/26 at 1:33 p.m., three (3) of the resident council members indicated food served during meal services was cold.A food temperature was requested in the second-floor dining room for the lunch service on 3/20/26 at 12:03 p.m. [NAME] 4 indicated he did not have a food thermometer available in the serving area. Upon returning to the second-floor dining room, after obtaining another kitchen staff member with a food thermometer from the main kitchen, the meal service had started.The food temperatures were obtained, on 3/20/26 at 12:07 p.m., from the second-floor dining room where five (5) food items were being held on the steam table for the lunch service.The following temperatures were obtained:a. The pureed carrots were 128 degrees Fahrenheit.b. The pureed beef pot roast was 103 degrees Fahrenheit.c. The hamburgers (an alternative option) were 119 degrees Fahrenheit.During an interview, on 3/20/26 at 12:09 p.m., [NAME] 4 indicated he believed the holding temperatures would be 160 degrees.During an interview, on 3/20/26 at 12:13 p.m., the Dietary Manager indicated the carrots, pureed beef pot roast, and the hamburgers were not at the appropriate holding temperatures and could not be served.A current facility policy, titled Pureed food preparation, dated as last revised 1/2025 and received from the Administrator on 3/20/26 at 12:00 p.m., indicated .Pureed foods will be prepared and served in a manner that maximized quality of flavor and nutrient content.Standardized recipes will be used to produce pureed food to maintain nutrient content.Milk, broth, soup, gravy, and margarine will be used to thin the pureed food instead of water. Water may only be used if mixed with a commercially available thickening agent to form a slurry.Pureed hot items will be prepared while maintaining a temperature above 135 degrees.A current facility policy, titled Food Temperatures, undated and received from the Administrator on 3/23/26 at 11:27 a.m., indicated .Food temperatures shall be checked at the end of cooking, at the start of service.Hot foods will be held at temperatures 135 degrees or above.prior to serving to maintain food safety.Inappropriate holding temperatures shall be reported to supervisor for corrective action or disposal instruction.Hot Food.Hold at 135 degrees Fahrenheit or greater throughout service process.410 IAC (Indiana Administrative Code) 3.1-21(a)(1)410 IAC (Indiana Administrative Code) 3.1-21(a)(2)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Reviews (PASARR) were resubmitted after psychotropic medications were initiated for newly identified behaviors, prior to the expiration for short term approvals, and for an increase in dosage of psychotropic medications for 4 of 6 residents reviewed for PASARR. (Resident 47, 3, 1 and 10)Findings include:1. The clinical record for Resident 47 was reviewed on [DATE] at 1:46 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety. A hospital document, dated [DATE], indicated Resident 47's wife reported being unable to care for him at home due to his severe dementia. Resident 47 did experience hallucinations but was never violent. Resident 47's hospital discharge medication list did not include a diagnosis of anxiety or medications for anxiety or agitation. A level I PASSAR screen, dated [DATE], indicated Resident 47's only mental health diagnosis was dementia. Resident 47 was prescribed Exelon (a medication used to treat mild-to-moderate dementia) to manage his dementia symptoms. A level II PASSAR was required at that time and if a change occurred or if new information refuted the findings, a new PASSAR must be submitted. The clinical record indicated Resident 47 was admitted to the facility on [DATE]. No behaviors were documented from [DATE] to [DATE]. A behavior note, dated [DATE], indicated Resident 47 had attempted to bust through the fire exit door by forcefully pressing his body against the door and hitting the door in attempt to get out. Interventions by the staff were unsuccessful and the behaviors continued for approximately 1 hour. A behavior note, dated [DATE], indicated Resident 47 was displaying physically aggressive behavior during the shift by yelling, cursing, and threatening to hit staff. Interventions attempted by the staff were unsuccessful and the behaviors continued for approximately 30 minutes. Staff contacted Resident 47's wife and indicated the resident's neurologist would fax a prescription for Valium (an antianxiety medication) to the facility. A behavior note, dated [DATE], indicated Resident 47 was physically aggressive by hitting staff with his walker and pushing the staff. The behavior decreased when his wife came to visit but increased again after his wife left. An interdisciplinary team (IDT) note, dated [DATE], indicated Resident 47 was displaying an increase in behaviors. The facility would evaluate the resident's medication with the psychiatric nurse practitioner and social service was made aware. A physician's order, dated [DATE] to [DATE], indicated to administer Valium 2 milligrams (mg) once a day, as needed, for anxiety and agitation related to dementia. A physician's order, dated [DATE] to [DATE], indicated to administer Valium 2 mg every 12 hours, as needed, for anxiety and agitation related to dementia. A physician's order, dated [DATE], indicated to administer buspirone (a medication used to treat (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anxiety) 5 mg, three times a day, for anxiety. A physician's order, dated [DATE], indicated to administer Valium 2 mg every 8 hours, as needed, for anxiety and irritability. A physician's order, dated [DATE], indicated to administer Valium 2 mg, at bedtime, for anxiety. A new PASSAR level I screen which included the resident's new diagnosis of anxiety and the new psychotropic medications of Valium and buspirone were not located in the medical record. During an interview, on [DATE] at 12:03 p.m., Resident 47's wife indicated the resident had started experiencing increased anger and his neurologist ordered Valium. During an interview, on [DATE], the Social Service Director indicated a new PASSAR would be submitted for the addition of psychotropic medications and Resident 47 should have had a new PASSAR submitted. 2. The clinical record for Resident 3 was reviewed on [DATE] at 12:35 p.m. The diagnoses included, but were not limited to, major depressive disorder, anxiety disorder, and bipolar disorder. A level I PASSAR screen, dated [DATE], indicated Resident 3's mental health medications included Seroquel (an antipsychotic medication), and a level II evaluation must be conducted. A level II PASSAR, dated [DATE], indicated Resident 3 had a 90-day short-term approval period and the approval period would end on [DATE]. A new level II PASSAR completed prior to the 90-day short-term approval period end date was not located in the clinical record. A physician's order, dated [DATE], indicated to administer buspirone 10 mg, two times a day, for anxiety. A PASSAR which included Resident 3's new psychotropic medication was not located in the clinical record. During an interview, on [DATE] at 4:00 p.m., the Social Service Director indicated a new PASSAR would be submitted for a change in psychotropic medications. When a short-term approval period was ending, the business office manager would be notified so they could start the process of submitting a new PASSAR. Resident 3's PASSAR was expired and should have been resubmitted. The Social Service Director needed to be notified when a short-term approval date was ending so the business office manager could initiate a referral for a new PASSAR. The facility had been trying to determine who would be responsible for ensuring PASSARs were submitted in a timely manner. 3. The clinical record for Resident 1 was reviewed on [DATE] at 11:15 a.m. The diagnoses included, but were not limited to, mild cognitive impairment, essential hypertension, and type 2 diabetes. A PASARR level I screen, dated [DATE], indicated the PASRR level I determination had an approval date of 60 days. The suspected or confirmed PASARR condition was an intellectual disability. If the resident needed to stay longer than the number of approved days listed on the notice, a nursing (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility staff member must submit a new level I screen. A PASARR resubmitted after the 60-day approval period was not located in the clinical record. During an interview, on [DATE] at 4:00 p.m., the Social Service Director indicated a new PASSAR would be submitted for a change in psychotropic medications. Before a short-term approval period ends, the business office manager would be notified so they could start the process of submitting a new PASSAR. 4. The clinical record for Resident 10 was reviewed on [DATE] at 2:09 p.m. The diagnoses included, but were not limited to, severe recurrent major depressive disorder without psychotic features, anxiety disorder, and chronic pain. A PASARR, dated [DATE], indicated the resident had diagnoses of depression and anxiety and was taking Cymbalta (a medication used to treat depression). A physician's order, dated [DATE], indicated to administer Cymbalta 40 mg two times a day. A physician's order, dated [DATE] and discontinued [DATE], indicated to administer buspirone (a medication used to treat anxiety) 5 mg twice a day. A physician's order, dated [DATE] and discontinued [DATE], indicated to administer buspirone 10 mg twice a day. A physician's order, dated [DATE] and discontinued [DATE], indicated to administer buspirone 5 mg twice a day. A physician's order, dated [DATE], indicated to administer buspirone 5 mg twice a day. A physician's visit note, dated [DATE], indicated the resident's scheduled current medications included buspirone and Cymbalta. During an interview, on [DATE] at 3:54 p.m., the Social Service Director indicated the facility had recently initiated a new PASARR screen for Resident 10. A new PASARR screen should have been completed when a new medication was started, with a new mental health diagnosis, or when the short-term approval expired. It should also have been initiated if the original PASARR screen was missing information. A current facility policy, titled Guidelines for PASRR Process, dated [DATE] and provided by Unit Manager 7 on [DATE] at 11:36 a.m., indicated PASRR is a federally mandated process that requires all states to pre-screen all residents.PASRR has 3 goals: 1) Identify people.with mental illness.3) To ensure people, (residents), receive the required services for mental illness. 410 IAC (Indiana Administrative Code) 16.2-3.1-16(d)(1)(A) 410 IAC (Indiana Administrative Code) 16.2-3.1-16(d)(1)(B)

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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. Based on interview and record review, the facility failed to ensure resident records were complete and accurate for 4 of 5 residents reviewed for resident records. (Resident 98, 7, 26 and 91)Findings include:1. The clinical record for Resident 98 was reviewed on 3/23/26 at 8:30 a.m. The diagnoses included, but were not limited to, acute respiratory failure, heart failure, and respiratory syncytial virus (RSV) pneumonia. A hospital document, dated 12/27/25, indicated Resident 98 was discharged from the hospital to the facility with diagnoses which included, but were not limited to, pneumonia of the left lower lobe and acute hypoxic respiratory failure. During Resident 98's hospital treatment course, the resident required high oxygen needs and at the time of discharge was utilizing 2 L (liters) of oxygen via nasal cannula. A written physician's telephone order, dated 12/27/25, indicated to administer oxygen at 2 liters per minute as needed for shortness of breath. The telephone order did not include the signature of the nurse who received the order or the date and time the order was received. The order for oxygen was not placed into the resident's electronic health record. An admission assessment, dated 12/27/25, indicated Resident 98 utilized oxygen at 2 liters via nasal cannula. A facility post-admission assessment, dated 12/28/25, indicated Resident 98's most recent oxygen saturation was 97% with oxygen via nasal cannula. The equipment needs were documented as No respiratory support or equipment noted. A care plan, dated 12/29/25, indicated Resident 98 was at risk for impaired gas exchange related to respiratory failure and the use of oxygen. An occupational therapy evaluation note, dated 12/29/25, indicated Resident 98's required oxygen dependance via nasal cannula at 2 liters. The electronic health record indicated Resident 98's oxygen saturations were documented 15 times. Of the 15 documented times, two were documented as room air. A transfer form, dated 1/9/26 at 5:23 p.m., indicated Resident 98 was being transferred to the hospital for respiratory arrest (breathing stopped but a pulse was still present). The vital signs were documented as 24 breaths per minute and an oxygen saturation of 91% with oxygen via nasal cannula. The respiratory devices and treatment section which would indicate if the resident was using oxygen, how many liters of oxygen were being used, and the method of delivery was left blank. A SBAR (situation, background, assessment and recommendation) form, dated 1/9/26, indicated the resident experienced respiratory arrest. Oxygen saturations were 91%. The room-air or oxygen use section was left blank. During an interview, on 3/24/26 at 2:30 p.m., the Director of Nursing (DON) indicated Resident 98 had to have an order for oxygen. She reviewed the physician's orders in the clinical record and indicated the order was missing and she was not sure why the oxygen order was not listed. (continued on next page)

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	03/26/2026

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 3/24/26 at 3:09 p.m., Unit Manager 7 indicated Resident 98 was not discharged from the hospital with an order for oxygen. Resident 98 did require oxygen while in the hospital but was to be weaned off the oxygen at the facility. There was documentation in the record of the resident's oxygen saturations on room air. Resident 98's identification picture in the clinical record showed the resident wearing a nasal cannula but there was no way of knowing if the nasal cannula was attached to an oxygen concentrator. On 1/9/26, Resident 98 became short of breath, the physician came to the facility, placed oxygen on the resident, and ordered Resident 98 be sent to the emergency room for evaluation. A review of the resident identifier picture, located in the clinical record, indicated the picture was taken on 12/29/25, two days after Resident 98 was admitted to the facility. During an interview, on 3/26/26 at 1:42 p.m., Unit Manager 7 indicated when she received a verbal or telephone order from the physician, she would document the date and time the order was given and sign the order form. She would then transcribe the order, give the order form to medical records, and report to the oncoming shift a new order was entered for the resident. 2. The clinical record for Resident 7 was reviewed 3/24/26 at 9:45 a.m. The electronic medical record did not include any record of tuberculosis testing. The facility added the tuberculosis testing to the clinical record on 3/25/26 at 11:10 a.m. The record did not indicate the times when the test was given or read, and it did not include the dates the tests were read. During an interview, on 3/26/26 at 3:05 p.m., the Assistant Director of Nursing (ADON) who served as the facility's Infection Preventionist indicated the tuberculosis tests must be read within 48-72 hours after administration, so she tried to make sure when she documented a test that she included the date and time it was read. The medical record should include the date and time the tests were given and read. 3. The clinical record for Resident 26 was reviewed on 3/24/26 at 2:57 p.m. The testing record indicated the tuberculosis tests were given on 7/21/25 and 7/29/25 at midnight with no indication of the date and time either were read. 4. The clinical record for Resident 91 was reviewed on 3/24/26 at 2:54 p.m. The admission tuberculosis tests were given on 4/18/25 and 7/28/25. The clinical record did not include the date or time either test was read. An immunization report, dated 3/25/26 at 11:04 a.m., was provided by Unit Manager 7 on 3/25/26 at 11:30 a.m., and indicated the tuberculosis tests were given on 4/18/25 and 5/2/25. The medical record did not include the date or time either test was read. The facility did not provide a resident admission tuberculosis policy. A current facility policy, titled Guidelines for Nursing Documentation, dated 5/17/23 and provided by Unit Manager 7 on 3/26/26 at 11:36 a.m., indicated .Be definite in what you record.Use quantifiable date.Be timely in your documentation. It is easy to forget details.Remember If you did not write it (continued on next page)

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	155556	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	down, you did not do it. If you did not do it, you were negligent 410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(1) 410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(2)

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	155556	A. Building B. Wing	03/26/2026

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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 an informed consent was obtained prior to initiating psychotropic medications for 1 of 5 residents reviewed for unnecessary medications. (Resident 47)Findings include:During an interview, on 3/19/26 at 12:03 p.m., Resident 47's wife indicated after being admitted to the facility Resident 47 experienced an increase in anger and his neurologist ordered Valium (an antianxiety medication). She picked up the prescription from the pharmacy and took the medication to the facility. Resident 47's wife indicated she did not sign an informed consent for the use of the medication and indicated the only person who had asked if she had any questions about the medication was at the pharmacy when she picked up the prescription.The clinical record for Resident 47 was reviewed on 3/23/26 at 1:46 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety.A physician's order, dated 2/28/26 to 3/5/26, indicated to administer Valium 2 milligrams (mg) once a day, as needed, for anxiety and agitation related to dementia.A physician's order, dated 3/5/26 to 3/14/26, indicated to administer Valium 2 mg every 12 hours, as needed, for anxiety and agitation related to dementia.A physician's order, dated 3/9/26, indicated to administer buspirone (an anxiety medication) 5 mg three times a day for anxiety.A physician's order, dated 3/14/26, indicated to administer Valium 2 mg every 8 hours, as needed, for anxiety and irritability.A physician's order, dated 3/18/26, indicated to administer Valium 2 mg at bedtime for anxiety.A signed informed consent for the medication changes related to the administration of Valium was not located in the clinical record.A signed informed consent for buspirone was not located in the clinical record.During an interview, on 3/26/26 at 12:12 p.m., the Social Service Director indicated signed informed consents were needed for all psychotropic medications. Buspirone did not have a black box icon next to the medication, so she did not know the medication needed a signed informed consent. If psychotropic medications needed a new signed informed consent after a dose increased, the nurse would inform the Social Service Director when the dosage increased.During an interview, on 3/26/26 at 3:39 p.m., the Director of Nursing (DON) indicated the facility followed all State and Federal regulations.A current facility policy, titled Guidelines for Behavioral Management, dated 8/18/23 and received from Unit Manager 7 on 3/26/26 at 11:36 a.m., indicated .The purpose is to review residents who have behaviors and who are being monitored for these behaviors.The facility will make every effort to comply with state and federal regulations related to the use of psychoactive medications, to include regular, structured review for continued need, appropriate dose, side effects, risks and benefits.Psychoactive medications include anti-anxiety/hypnotic, anti-psychotic and anti-depressants.Documents discussions with the resident and/or responsible party regarding the risks verses the benefits of the use of these medications to include documented discussion of any black box warning associated with specific medication.410 IAC (Indiana Administrative Code) 3.1-3(n)(2)

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	155556	A. Building B. Wing	03/26/2026

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Waters of Tipton Skilled Nursing Facility, The	300 Fairgrounds Rd Tipton, IN 46072

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure the physician was notified of a resident's significant weight loss for 1 of 3 residents reviewed for notification of change. (Resident 7)Findings include:During an observation, on 3/19/26 at 12:26 p.m., Resident 7 was not eating her lunch. The CNA charting indicated the resident refused her lunch. No replacement meal or alternatives offered were charted for her lunch, on 3/19/26.During an observation, on 3/20/26 at 12:37 p.m., Resident 7 ate less than half her lunch.The clinical record for Resident 7 was reviewed on 3/24/26 at 9:45 a.m. The diagnoses included, but were not limited to, dementia, major depressive disorder, muscle weakness, muscle wasting and atrophy of the right and left arms, and cognitive communication deficit.A hospital discharge document, dated 11/18/25, indicated Resident 7's current ongoing problems included weight loss and malnutrition and the most recent weight in the last 24 hours was 181 lbs. The facility weight log indicated, on 11/18/25, Resident 7 weighed 180.6 pounds.The facility weight log indicated, on 12/8/25, Resident 7 weighed 160 pounds which was a 11.41% weight loss. The admission weight of 180.6 pounds was cancelled as a data entry error by the dietician, on 12/9/25, with no progress note to indicate why the weight was considered invalid and was cancelled.There was no documentation the physician was notified of the weight change. A skilled nursing progress note, dated 12/8/25 at 9:25 a.m., indicated the resident weighed 160 pounds.A physician's progress note, dated 12/14/25, indicated Resident 7's weight was 180.6 pounds. There was no indication the physician was informed of weight loss or the 160-pound weight documented on 12/8/25.A weight summary indicated, on 1/4/26, Resident 7 weighed 149.3 pounds which was a 6.69% weight loss from the 160-pound weight documented on 12/8/25.A physician's progress note, dated 1/6/26 at 8:53 a.m., indicated the physician was new to the resident and had just taken over her care. Her weight was listed at 149.3 pounds. There was no documentation on prior weights, or the facility had informed the physician of the resident's weight loss.A weight log, dated 1/11/26, indicated Resident 7 weighed 146.4 pounds which was an 8.5% loss in a month from the 160 pounds on 12/8/25. A weight record, dated 2/15/26, indicated Resident 7 weighed 143.9 pounds which was a 10.06% weight loss in less than 3 months from the 160 pounds, on 12/8/25.A physician's progress note, dated 3/17/26 at 10:05 a.m., did not indicate the facility had notified the physician or Resident 7 was assessed for a significant weight loss.A weight summary, dated 3/23/26, indicated Resident 7's current weight was 140.7 pounds.The documented 181-pound weight, on 11/18/25, and the documented 140.7-pound weight, on 3/23/26, would be an approximate 22% weight loss in approximately 4 months and 5 days. During an interview, on 3/25/26 at 2:45 p.m., LPN 5 indicated Resident 7 needed cueing and encouragement to eat most of the time. Resident 7 did not have any weight loss concerns being monitored by nursing.During an interview, on 3/26/26 at 10:47 a.m., the Director of Nursing (DON) indicated Resident 7 was admitted after having sepsis in the hospital where she had been given a lot of fluids and diuretics, so the facility had expected some weight loss. The facility was not following her for weight loss even after weight loss had continued for months after her hospital discharge and no longer receiving any diuretics.The DON did not provide any documentation or indication the physician had been notified and evaluated the resident for significant weight loss. The resident had switched physicians in January.A current facility policy, titled S-W-A-T PROGRAM (SKIN AND WEIGHT ASSESSMENT TEAM) WEIGHT MANAGEMENT, dated 10/9/23 and provided by the Assistant Director of Nursing (ADON) on 3/26/26 at 1:45 p.m., indicated .assess.notifications made to MD, RD, Family.410 IAC (Indiana Administrative Code) 16.2-3.1-5(a)(2)410 IAC (Indiana Administrative Code) 16.2-3.1-5(a)(3)

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	155556	A. Building B. Wing	03/26/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview and record review, the facility failed to ensure a physician's order related to a medical condition was obtained for the use of a bed and chair alarm, an initial physical restraint assessment was completed, and an interdisciplinary team (IDT) note which discussed the least restrictive interventions implemented first had failed and to review the use of the devices at least quarterly for 1 of 2 residents reviewed for physical restraints. (Resident 81)Findings include:During an observation, on 3/20/26 at 2:19 p.m., Resident 81 had a pull alarm (a device designed to alarm staff when the resident attempted to get up) connected to the resident and her wheelchair. The resident had a device in her room connected to the bed as well.The clinical record for Resident 81 was reviewed on 3/24/26 at 10:55 a.m. The diagnoses included, but were not limited to, major depressive disorder, muscle weakness, and dementia.A physician's order, dated 9/24/25, indicated to utilize a pull alarm when in the wheelchair every shift.The order had no related diagnosis or indication for use. There was an indefinite end date.A physician's order, dated 9/24/25, indicated to utilize a bed alarm when in bed every shift.The order had no related diagnosis or indication for use. There was an indefinite end date.The clinical record indicated Resident 81 had a fall on 1/26/25 and on 9/24/25. The bed alarm and chair alarm orders were placed after the fall on 9/24/25.Resident 81 had no documented falls after 9/24/25. The facility continued the ordered bed and chair alarm after the resident had gone over 7 months without a recorded fall.An IDT progress note, dated 9/25/25, indicated the IDT team met to discuss the fall which happened on 9/24/25. The resident was found on the floor at approximately 11 a.m. A bruise was noted on her right elbow. The immediate intervention was a pull alarm placed on the wheelchair. The IDT team recommended continuing the alarm at this time with routine evaluations to ensure appropriateness.The IDT team note did not discuss which least restrictive interventions were attempted and failed prior to initiating the alarm.The clinical record did not indicate an initial physical restraint assessment was completed and there was no physical restraint/device assessment completed at least quarterly. During an interview, on 3/24/26 at 10:55 a.m., the Director of Nursing (DON) indicated she understood there was not much documentation in the record about the devices. The facility did reassess the need for the devices and she would work on finding the reassessments.During an interview, on 3/24/25 at 3:50 p.m., the DON indicated she would be providing the device reassessments.A fall assessment for Resident 81 was received from the facility on 3/25/26 at 8:45 a.m. There was no mention of the alarm devices in the fall assessments.During an interview, on 3/25/26 at 3:40 p.m., the DON indicated it did not appear Resident 81 needed the bed and chair alarms.During an interview, on 3/26/26 at 3:39 p.m., the DON indicated the facility followed all federal and state regulations.During an exit conference, on 3/26/26 at 4:23 p.m., the DON indicated the facility had no additional information to submit for review.A current facility policy, titled Guidelines for Physical Restraints/Seclusion, dated 5/17/23 and received from the Executive Director on 3/25/26 at 1:40 p.m., indicated .It is the policy of the facility to use physical restraint only as a last resort and only after every other alternative to a physical restraint (based on assessment) that seemed to have the potential for being used successfully, has been tried, and has failed. The use of a physical restraint and/or device is to enable and promote functioning at the highest practicable physical, mental, or psychosocial well-being. It will be used only after the resident has been assessed and it has been determined by the IDT that the restraint to be used is the least restrictive and for the least amount of time.The resident must have a complete order for the restraint which includes the type of restraint and when it is to be applied/released. The restraint order must include the related medical condition.Procedure A. Complete the initial Physical Restraint Assessment. Note: If a resident is admitted with a physical restraint, a new assessment/order is needed. B. Review contributing factors such as behaviors/mood/fall risk/medical signs and symptoms/diagnosis/cognition/communication and ADL performance (continued on next page)

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	155556	A. Building B. Wing	03/26/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abilities. C. IDT to evaluate alternatives to physical restraint use and least restrictive interventions for the least amount of time. D. Explain and document the risks and benefits of treatment options related to physical restraints/devices to the resident as well as the representative (if the resident is not their own responsible party). E. Obtain the consent of the resident or of their representative/POA (if the resident is not their own responsible party). F. Obtain a detailed and specific doctor's order for the physical restraint/device which includes the specific physical restraint/device as well as when it is to be applied and released. J. Complete a new Physical Restraint/Device Assessment at least quarterly or if there is a change in the resident's condition (or if the medical condition for which the physical restraint is being used changes) to see if a lesser restraint can be used-or for possible the discontinuance of the physical restraint if possible.Note: Always try a restraint alternative before using a physical restraint/device 410 IAC (Indiana Administrative Code) 16.2-3.1-26(a)410 IAC (Indiana Administrative Code) 16.2-3.1-26(o)410 IAC (Indiana Administrative Code) 16.2-3.1-26(r)410 IAC (Indiana Administrative Code) 16.2-3.1-26(s)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure a bed hold policy was provided to the resident or resident's representative at the time of transfer for 1 of 2 residents reviewed for hospitalization. (Resident 78)Findings include:The clinical record for Resident 78 was reviewed on 3/24/26 at 2:34 p.m. The diagnoses included, but were not limited to, repeated falls, history of falling, and dementia.A progress note, dated 6/25/25, indicated Resident 78 was noted to be on the floor and complained of back pain. The resident was transferred by Emergency Medical Services (EMS) to the hospital.The clinical record did not indicate the bed hold policy was provided to the resident or resident's representative at the time of transfer.During an interview, on 3/26/26 at 9:56 a.m., Social Services14 indicated the staff should document when the bed hold policy was provided to the resident or resident's representative when a resident was transferred to the hospital.During an interview, on 3/26/26 at 10:12 a.m., Social Services14 indicated she found the note about the transfer, but it did not say anything about bed hold information being provided.The facility did not have a policy related to providing bed hold information to the resident and resident's representative at the time of transfer.410 IAC (Indiana Administrative Code) 16.2-3.1-12(a)(25)(A)410 IAC (Indiana Administrative Code) 16.2-3.1-12(a)(25)(B)410 IAC (Indiana Administrative Code) 16.2-3.1-12(a)(26)

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	03/26/2026

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview and record review, the facility failed to ensure mental health services were provided for a resident with several mental health disorders for 1 of 4 residents reviewed for mood and behavior. (Resident 12)Findings include:During an observation and interview, on 3/19/26 at 10:37 a.m., Resident 12 was in bed and indicated she did not receive mental health services but would like to attend therapy sessions.During an observation and interview, on 3/25/26 at 1:57 p.m., Resident 12 was in bed and was thinking about going to the ice cream bar activity downstairs. She indicated staff had not asked if she would like to attend therapy and wished staff would because she could use it.The clinical record for Resident 12 was reviewed on 3/23/26 at 12:36 p.m. The diagnoses included, but were not limited to, bipolar disorder, conversion disorder, anxiety disorder, post-traumatic stress disorder, panic disorder, delusional disorder, and dementia.Resident 12 was admitted to the facility, on 9/5/25, after an extended in-patient stay at a psychiatric hospital.A physician's order, dated 9/5/25, indicated Resident 12 could receive the services of a psychiatrist.A physician's order, dated 9/5/25, indicated Resident 12 could receive counseling and medication management services.A patient registration form indicated consent for behavioral health services was obtained from Resident 12's next of kin on 9/5/25.A care plan, dated 9/8/25, indicated Resident 12 had a diagnosis of anxiety with an intervention of psych per order.A physician's order, discontinued 10/12/25, indicated Resident 12 could be evaluated and treated for psychology and psychiatry services.A level of care document, dated 11/17/25, indicated there were zero days of psychological therapy for Resident 12 by any licensed mental health professional.A PASSAR (Preadmission Screening and Resident Review), dated 11/19/25, indicated the facility was required to provide Resident 12 mental health services such as individual therapy.The clinical record did not contain documentation of mental health services for Resident 12 from 9/5/25 to 1/11/26.A psychiatric note, dated 1/12/26, indicated Resident 12 had a two-way video and audio initial patient visit to evaluate her psychiatric conditions to determine if the mental health services would assist in the management, education, and support of the resident's conditions. The summary of the visit indicated Resident 12 was eligible for behavioral health integration and psychiatric collaborative care management, and a consent to enroll for these services had been signed by the resident.A care plan, dated 2/6/26, indicated Resident 12 had a diagnosis of Post-Traumatic Stress Disorder (PTSD) with an intervention to refer the resident for psychiatric services.A care plan, dated 2/6/26, indicated Resident 12 required the use of antipsychotic medications related to her mental health disorders with an intervention to refer her to psychiatric services.A care plan, dated 2/6/26, indicated Resident 12 had a history of severe, persistent mental illness with an intervention to refer her to appropriate individual counseling or other mental health program.A care plan, dated 2/6/26, indicated Resident 12 had a history of mental illness and mental health needs with interventions to provide initial psychiatric management to monitor psychotropic medications and to help support and enhance structure, inform the psychiatrist of the resident's progress, and to involve the resident in supportive group and/or one-on-one counseling.A psychotherapeutic drug evaluation, dated 3/5/26, indicated Resident 12 was receiving psychiatric services.The clinical record did not contain documentation of mental health services for Resident 12 from 1/13/26 to 3/26/26.A quarterly social service resident interview, dated 3/10/26, indicated during a 7-day look back period from 3/4/26 to 3/10/26, Resident 12 had admitted to experiencing little pleasure in doing things she liked to do, feeling down and depressed, having difficulty falling asleep, feeling tired and having difficulty concentrating. Resident 12's PHQ-9 (a questionnaire which assessed the degree of depression severity) was a 13 out of 27 which indicated moderate depression.An encounter note, dated 3/10/25, from a company which provided on-site care for long-term care residents, indicated Resident 12 was being seen for an initial evaluation of her chronic medical conditions.During an interview, on 3/24/26 at 9:57 a.m., LPN (Licensed Practical Nurse) 9 (continued on next page)

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	03/26/2026

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated not all the residents in the facility were seen by the company the facility utilized for on-site care of the residents. The company had their own physicians who come to the facility to see the residents who were members.During an interview, on 3/24/26 at 3:42 p.m., the Social Service Director indicated Resident 12 needed mental health services.During an interview, on 3/25/26 at 10:26 a.m., Unit Manager 7 indicated Resident 12 had been seen by the facility Medical Director who had reviewed the resident's medications but did not want to make changes to her mental health medications until she had been seen by a psychiatric provider. Resident 12 was not currently being seen by a psychiatric provider or receiving mental health services.During an interview, on 3/26/26 at 3:39 p.m., the Director of Nursing indicated the facility did not have a policy regarding mental health services. The facility followed all State and Federal regulations.410 IAC (Indiana Administrative Code) 3.1-43(a)(1)410 IAC (Indiana Administrative Code) 3.1-43(a)(2)

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	03/26/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medication carts were free from expired medications and medications were properly labeled with a pharmacy label for 2 of 3 medication carts reviewed for medication storage and labeling. (orchard cart and garden cart)Findings include:1. The orchard hall medication cart was reviewed on 3/25/26 at 1:34 p.m. The following were observed:a. In the fifth large drawer, a prescription bottle of levothyroxine (a medication used to treat an underactive thyroid) 200 milligrams (mg) contained several small round pills. The medication bottle had a discard after date of 1/4/25. Expired was written in pink ink on the pharmacy label.During an interview, on 3/25/26 at 1:49 p.m., LPN (Licensed Practical Nurse) 5 indicated she believed expired medications should be taken out of the medication cart.2. The garden hall medication cart was reviewed on 3/25/26 at 1:59 p.m. The following were observed:a. In the first large drawer, a Humalog insulin pen (a rapid acting inulin used to control blood sugar) did not contain a pharmacy label and was in a medication zip-lock bag with another lispro insulin pen. The zip-lock bag contained a pharmacy label for the lispro insulin pen.b. In the fourth large drawer, a single dose of amoxicillin/clavulanate potassium (a combination antibiotic medication), sealed in the manufactures packaging, was sitting loose in the drawer and did not contain a pharmacy label.During an interview, on 3/25/26 at 2:21 p.m., LPN 6 indicated medications should have a pharmacy label. If the pharmacy label came off the medication, the nurse should write the resident's last name, provider's name and see MAR (Medication Administration Record) on the medication packaging.During an interview, on 3/26/26 at 10:19 a.m., Unit Manager 7 indicated the Humalog insulin pen and the single dose of amoxicillin/clavulanate potassium were pulled from the EDK (emergency drug kit). Medications pulled from the EDK did not come with a pharmacy label and should be labeled by the nurse at the time the medication was removed from the EDK with the resident's name, room number, and physician's name.During an interview, on 3/26/26 at 10:22 a.m., Unit Manager 8 indicated when a new order was put into the resident's record, the Unit Manager would sometimes get the medication out of the EDK for the nurse working on the floor. She had pulled 2 doses of amoxicillin/clavulanate potassium sometime before lunch for the afternoon and evening administration times and gave the medications to the nurse.A current facility policy, titled Medication Storage In The Facility, dated 10/2021 and received from Unit Manager 7 at 11:41 a.m., indicated .Medications and biologicals are stored safety, securely, and properly following the manufacture or supplier recommendations.Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled, or without secure closures will be immediately withdrawn from the stock by the facility. They will be disposed of according to drug disposal procedures and reordered from the pharmacy if a current order exists.410 IAC (Indiana Administrative Code) 3.1-25(j)410 IAC (Indiana Administrative Code) 3.1-25(o)

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	03/26/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff followed enhanced barrier precautions and wore personal protective equipment which included a gown during catheter care for 1 of 1 resident randomly observed for infection control. (Resident 93)Findings include:During an observation of catheter care, on 3/24/26 at 11:05 a.m., CNA 13 and Unit Manager 7 were in the room for Resident 93's catheter care. CNA 13 performed catheter care and did not wear a gown during the process.The clinical record for Resident 93 was reviewed on 3/24/26 at 3:26 p.m. The diagnoses included, but were not limited to, benign neoplasm of the bladder, neuromuscular dysfunction of the bladder, and a stroke affecting the left non-dominant side.A physician's order, dated 12/17/25, indicated enhanced barrier precautions every shift for the indwelling catheter.During an interview, on 3/24/26 at 11:16 a.m., Unit Manager 7 indicated a gown should be worn when performing catheter care.During an interview, on 3/24/26 at 12:24 p.m., the Director of Nursing (DON) indicated staff should use a gown when performing catheter care.A current facility policy, titled GUIDELINES for ENHANCED BARRIER PRECAUTIONS-(EBP) An extension of Personal Protective Equipment---(PPE), dated as reviewed December 2022 and received from the Executive Director on 3/26/26 at 8:30 a.m., indicated .It is the policy of the facility to ensure that additional and appropriate PPE (Personal Protective Equipment) is utilized, when indicated, to prevent the spread of Multidrug-resistant Organisms also known as MDROs. Enhanced Barrier Precautions (EBP): Enhanced Barrier Precautions are defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of [NAME] in the form of blood or body fluids, onto the hands and/or clothing of the rendering caregiver.Examples of High Contact Resident Care Activities at which time EBP is to be practiced are.Device Care or Use of to include: Central Lines. Urinary Catheters.410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)(2)