STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155006	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Wabash Skilled Nursing Facility East The	1900 N Alber St Wabash, IN 46992

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to ensure an allegation of staff to resident physical and verbal abuse was reported to the State Agency (Indiana Department of Health) for 1 of 3 residents reviewed for abuse. (Resident E)Findings include:Resident E's clinical record was reviewed on 12/10/25 at 9:50 a.m. Diagnoses included dementia and major depressive disorder.Current physician's orders included behavior monitoring every shift for restlessness, nervousness, mood disturbances (8/7/25), memantine 10 mg give one tablet by mouth every morning and at bedtime for dementia (11/2/23), and sertraline 100 mg give one table in the morning for depression (3/7/25).A quarterly Minimum Data Set (MDS) assessment, dated 9/17/25, indicated Resident E was severely cognitively impaired, did not experience hallucinations or delusions, and displayed no physical or verbal symptoms towards others during the assessment period.A care plan, initiated 11/17/25, indicated Resident E displayed behavioral symptoms related to dementia which included restlessness, nervousness, and mood disturbances. Interventions included administering psycho-active medications as ordered, recording behavioral symptoms of verbal/physical aggression and inappropriate behaviors, intervene when any inappropriate behavior was observed, and use creative refocusing to alter behavioral patterns.During an interview with the Dietary Manager (DM), on 12/8/25 at 12:59 p.m., she indicated, on 11/3/25, she observed CNA 2 become aggressive with Resident E during lunch. Resident E was sitting at her dining table when CNA 2 placed a drink for another resident on the table. When Resident E and CNA 2 reached for the drink at the same time, Resident E scratched the CNA's hand. CNA 2 grabbed both Resident E's wrists and in a very loud voice said, Don't scratch me!. The DM indicated she went to the DON's office to report the incident. She was later told, by the Administrator, there were no findings regarding the incident. The DM asked the Administrator if he needed her written statement and he said he did not need one.During an interview with the Administrator on 12/8/25 at 1:24 p.m., he indicated there had been no report(s) of abuse from staff in the past 60 days and no grievances were filed during that time.During an interview with the Administrator on 12/8/25 at 3:16 p.m., he indicated he was ill the week of the alleged incident. Resident E required cues or reminders to eat. CNA 3 first brought the incident to his attention on an unknown date. CNA 3 heard the DM talking about something happening during lunch service. He did an investigation but had no findings. The Administrator indicated the DM was not a reliable witness. Approximately two weeks before the 11/3/25 incident, during an interdisciplinary team meeting (IDT), the DM had told him she wanted CNA 2 fired or she would walk that day. The DM and CNA 2 had a history outside of working at the facility. The Administrator did not think the 11/3/25 incident was reportable. He talked to CNA 2, who told him she said We don't scratch like that, honey when Resident E tried to scratch her. He had no complaints from residents regarding CNA 2. He did have complaints from other staff members regarding CNA 2. He had not heard about hands being put on Resident E until the next IDT meeting. The DM had tried to do her own investigation and reported the incident to the DON while he was out sick. He later went to the (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DM and told her that at no point should she ever be doing her own investigation. If she truly thought she witnessed abuse, she would have called the police. The Administrator indicated he should have reported the allegation of abuse to IDOH.During an interview with CNA 3 on 12/8/25 at 3:33 p.m., she indicated she did not see anything between Resident E and CNA 2, but was standing at the service window to the kitchen when she heard the DM telling another staff member about the alleged incident. The DM said she was sick and tired of CNA 2 treating the residents poorly and putting their hands on them. CNA 3 had never seen CNA 2 put her hands on residents or speak rudely to them. CNA 3 did not know the reason but knew the DM and CNA 2 did not like each other.During an interview with the DON on 12/8/25 at 4:05 p.m., she indicated she was in the Social Services Director's (SSD) office when the DM entered and said she had tried to check the cameras because she saw CNA 2 grab Resident E by the face. The DM wanted to report the incident to the Administrator. The DON contacted the Administrator at home. After the DM left the office, CNA 3 reported the DM was slamming things in the kitchen, saying CNA 2 grabbed Resident E by the face. CNA 3 did not see or hear anything during the lunch service. CNA 2 was interviewed and was completely confused about the allegation of abuse. CNA 2 described the incident where Resident E tried to take a drink and tried to scratch the CNA. CNA 2 pulled away and said No, we don't scratch. The DON said there was no way the DM could have seen anything happen from her vantage point in the kitchen. Nobody complained about CNA 2 being rude or rough with residents. After speaking with CNA 2, nobody else saw anything and the DON let the Administrator know of her findings. Resident E could be very aggressive and there were times when CNA 2 could have been on the receiving end of Resident E fighting or resisting care. The Administrator was responsible for reporting alleged incidents of abuse to the state. That was why she called him right after the DM made the allegation of abuse. If the Administrator was unavailable to report an incident of abuse, the DON would contact a corporate consultant. She could not recall if she had collected written statements from the DM, CNA 2, or CNA 3.During an interview with CNA 2 on 12/10/25 at 10:55 a.m., she indicated she was called into the DON's office because the DM had reported to the DON an allegation of CNA 2 being abusive to a resident. On 11/3/25, during lunch service, she was passing drinks when Resident E grabbed another resident's drink. CNA 2 took the drink from Resident E and said, You can't have that, it is someone else's drink. CNA 2 told the DON to pull camera footage to see what happened. CNA 2 had never hit or pinched a resident. The DM complained about CNAs all the time. CNA 2 was usually one of them. For some reason, the DM just did not like CNA 2.An untitled document, dated 11/3/25 and provided by the Administrator on 12/10/25 at 3:15 p.m., indicated the entire IDT was present and called the Administrator, due to being out of the facility. During that phone call, the DM said she wanted to see the cameras because she was unsure about the behavior towards Resident E, and another aide (CNA 3) was present. When CNA 2 was loud with Resident E, the DM made the comment I'm not sure it happened, but I can see CNA 2 doing that. Immediately, while still on the phone, the DON went and got CNA 3 for a statement. CNA 3 stated that no such thing happened while she was in the dining room. CNA 3 stated that she was speaking to Resident E. Resident is a cue whom, while attempting to grab an item from the table, reached to scratch CNA 2, who backed away from the scratch and stated, 'We don't scratch (resident's name).' Then the Administrator and DON called CNA 2, who was confused as to what was said, stated that while she had told Resident E not to scratch, her level of speaking was appropriate and suggested we speak to CNA 3 who had already been interviewed. Assessments were completed for Resident E and the SSD noted no red marks to face or arms. At that time, the Administrator, DON, and SSD felt that the statement from the DM was not reason to pursue further action. The document was signed by the Administrator, DON, ADON, and SSD.During an interview with the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator on 12/10/25 at 3:15 p.m., he indicated the 11/3/25, untitled statement was written on 12/10/25 at 12:10 p.m.A current facility policy, titled Abuse Prevention Program, provided by the Administrator on 12/10/25 at 10:47 a.m., indicated the following: . It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings. The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party.IV. Identification - Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator or an immediate supervisor who will immediately report the allegation to the Administrator. The Administrator is the Abuse Coordinator.If you suspect abuse - Separate the alleged perpetrator and assure all residents safety, notify a Supervisor/Nurse Immediately, notify the Administrator and Director of Nursing, or the person in charge of the facility by page (to summon them to the area) or by telephone, complete the documentation of the incident in the EMR under the Risk Management section, DO NOT LEAVE the building until above is completed, the Administrator or designee utilizing the Incident Reporting System (IRS) will immediately notify the Department of Health by the online system or per the direction given by the Department of Health.V. Investigation - All incidents will be documented, whether or not abuse occurred, was alleged or suspected, any incident or allegation involving abuse or mistreatment will result in an abuse investigation, for any incident involving suspicion of abuse, neglect, or mistreatment, the Administrator or person appointed by the Administrator will gather further facts prior to making a determination to conduct an abuse investigation, once the Administrator designee determines that there is a reasonable cause for suspecting abuse, the Administrator designee will investigate the allegation and obtain a copy of any documentation relative to the incident. the Charge Nurse must complete an incident report and obtain a written, signed and dated statement from the person reporting the incident, a completed copy of the incident report and written statements from the witnesses, if any, will be provided to the Administrator within twenty-four (24) hours of the occurrence of such incident.VI. The facility will take steps to prevent mistreatment while the investigation is underway, residents and visitors are protected from any retaliation or possible harm, staff members who are suspected of abuse or misconduct shall immediately (regardless of time left on shift) be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation, prosecution, or disciplinary action against the employee.Cross reference F610.This citation relates to Intake 2671909. 3.1-28(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to investigate an allegation of staff to resident abuse and failed to implement the facility policy to protect residents following an allegation of abuse for 1 of 3 residents reviewed for abuse. (Resident E)Findings include:An anonymous allegation of staff to resident verbal abuse involving Resident E was received by the Indiana Department of Health on 11/14/25. During an interview with the Dietary Manager (DM), on 12/8/25 at 12:59 p.m., she indicated, on 11/3/25, she observed CNA 2 become aggressive with Resident E during lunch. Resident E was sitting at her dining table when CNA 2 placed a drink for another resident on the table. When Resident E and CNA 2 reached for the drink at the same time, Resident E scratched the CNA's hand. CNA 2 grabbed both Resident E's wrists and in a very loud voice said, Don't scratch me!. The DM indicated she went to the DON's office to report the incident. She was later told, by the Administrator, there were no findings regarding the incident. The DM asked the Administrator if he needed her written statement and he said he did not need one.During an interview with the Administrator on 12/8/25 at 1:24 p.m., he indicated there had been no report(s) of abuse from staff in the past 60 days and no grievances were filed during that time.During an interview with the Administrator on 12/8/25 at 3:16 p.m., he indicated he was ill the week of the alleged incident. Resident E required cues or reminders to eat. CNA 3 first brought the incident to his attention on an unknown date. CNA 3 heard the DM talking about something happening during lunch service. He did an investigation but had no findings. The Administrator indicated the DM was not a reliable witness. Approximately two weeks before the 11/3/25 incident, during an interdisciplinary team meeting (IDT), the DM had told him she wanted CNA 2 fired or she would walk that day. The DM and CNA 2 had a history outside of working at the facility. The Administrator did not think the 11/3/25 incident was reportable. He talked to CNA 2, who told him she said We don't scratch like that, honey when Resident E tried to scratch her. He had no complaints from residents regarding CNA 2. He did have complaints from other staff members regarding CNA 2. He had not heard about hands being put on Resident E until the next IDT meeting. The DM had tried to do her own investigation and reported the incident to the DON while he was out sick. He later went to the DM and told her that at no point should she ever be doing her own investigation. If she truly thought she witnessed abuse, she would have called the police. The Administrator indicated he should have reported the allegation of abuse to IDOH.During an interview with the DON on 12/8/25 at 4:05 p.m., she indicated she was in the Social Services Director's (SSD) office when the DM entered and said she had tried to check the cameras because she saw CNA 2 grab Resident E by the face. The DM wanted to report the incident to the Administrator. The DON contacted the Administrator at home. After the DM left the office, CNA 3 reported the DM was slamming things in the kitchen, saying CNA 2 grabbed Resident E by the face. CNA 3 did not see or hear anything during the lunch service. CNA 2 was interviewed and was completely confused about the allegation of abuse. CNA 2 described the incident where Resident E tried to take a drink and tried to scratch the CNA. CNA 2 pulled away and said No, we don't scratch. The DON said there was no way the DM could have seen anything happen from her vantage point in the kitchen. Nobody complained about CNA 2 being rude or rough with residents. After speaking with CNA 2, nobody else saw anything and the DON let the Administrator know of her findings. Resident E could be very aggressive and there were times when CNA 2 could have been on the receiving end of Resident E fighting or resisting care. The Administrator was responsible for reporting alleged incidents of abuse to the state. That was why she called him right after the DM made the allegation of abuse. If the Administrator was unavailable to report an incident of abuse, the DON would contact a corporate consultant. She could not recall if she had collected written statements from the DM, CNA 2, or CNA 3.Resident E's (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clinical record was reviewed on 12/10/25 at 9:50 a.m. Diagnoses included dementia and major depressive disorder.Current physician's orders included behavior monitoring every shift for restlessness, nervousness, mood disturbances (8/7/25), memantine 10 mg give one tablet by mouth every morning and at bedtime for dementia (11/2/23), and sertraline 100 mg give one table in the morning for depression (3/7/25).A quarterly Minimum Data Set (MDS) assessment, dated 9/17/25, indicated Resident E was severely cognitively impaired, did not experience hallucinations or delusions, and displayed no physical or verbal symptoms towards others during the assessment period.A care plan, initiated 11/17/25, indicated Resident E displayed behavioral symptoms related to dementia which included restlessness, nervousness, and mood disturbances. Interventions included administering psycho-active medications as ordered, recording behavioral symptoms of verbal/physical aggression and inappropriate behaviors, intervene when any inappropriate behavior was observed, and use creative refocusing to alter behavioral patterns.An untitled document, dated 11/3/25 and provided by the Administrator on 12/10/25 at 3:15 p.m., indicated the entire IDT was present and called the Administrator, due to being out of the facility. During that phone call, the DM said she wanted to see the cameras because she was unsure about the behavior towards Resident E, and another aide (CNA 3) was present. When CNA 2 was loud with Resident E, the DM made the comment I'm not sure it happened, but I can see CNA 2 doing that. Immediately, while still on the phone, the DON went and got CNA 3 for a statement. CNA 3 stated that no such thing happened while she was in the dining room. CNA 3 stated that she was speaking to Resident E. Resident is a cue whom, while attempting to grab an item from the table, reached to scratch CNA 2, who backed away from the scratch and stated, 'We don't scratch (resident's name).' Then the Administrator and DON called CNA 2, who was confused as to what was said, stated that while she had told Resident E not to scratch, her level of speaking was appropriate and suggested we speak to CNA 3 who had already been interviewed. Assessments were completed for Resident E and the SSD noted no red marks to face or arms. At that time, the Administrator, DON, and SSD felt that the statement from the DM was not reason to pursue further action. The document was signed by the Administrator, DON, ADON, and SSD.During an interview with the Administrator on 12/10/25 at 3:15 p.m., he indicated the 11/3/25, untitled statement was written on 12/10/25 at 12:10 p.m.A current facility policy, titled Abuse Prevention Program, provided by the Administrator on 12/10/25 at 10:47 a.m., indicated the following: . It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings. The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party.IV. Identification - Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator or an immediate supervisor who will immediately report the allegation to the Administrator. The Administrator is the Abuse Coordinator.If you suspect abuse - Separate the alleged perpetrator and assure all residents safety, notify a Supervisor/Nurse Immediately, notify the Administrator and Director of Nursing, or the person in charge of the facility by page (to summon them to the area) or by telephone, complete the documentation of the incident in the EMR under the Risk Management section, DO NOT LEAVE the building until above is completed, the Administrator or designee utilizing the Incident Reporting System (IRS) will immediately notify the Department of Health by the online system or per the direction given by the Department of Health.V. Investigation - All incidents will be documented, whether or not abuse occurred, was alleged or suspected, any incident or allegation involving abuse or mistreatment will result in an abuse (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation, for any incident involving suspicion of abuse, neglect, or mistreatment, the Administrator or person appointed by the Administrator will gather further facts prior to making a determination to conduct an abuse investigation, once the Administrator designee determines that there is a reasonable cause for suspecting abuse, the Administrator designee will investigate the allegation and obtain a copy of any documentation relative to the incident. the Charge Nurse must complete an incident report and obtain a written, signed and dated statement from the person reporting the incident, a completed copy of the incident report and written statements from the witnesses, if any, will be provided to the Administrator within twenty-four (24) hours of the occurrence of such incident.VI. The facility will take steps to prevent mistreatment while the investigation is underway, residents and visitors are protected from any retaliation or possible harm, staff members who are suspected of abuse or misconduct shall immediately (regardless of time left on shift) be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation, prosecution, or disciplinary action against the employee.This citation relates to Intake 2671909. 3.1-28(c)