STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 00 B. WING	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MUNCIE, THE	2400 CHATEAU DR MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00457987, IN00459011, and IN00459159. Complaint IN00457987- No deficiencies related to the allegations are cited. Complaint IN00459011- No deficiencies related to the allegations are cited. Complaint IN00459159- Federal/state deficiencies related to the allegations are cited at F607, F609, and F744. Survey dates: May 14 and 15, 2025 Facility number: 000310 Provider number: 155443 AIM number: 100288970 Census Bed Type: SNF/NF: 44 Total: 44 Census Payor Type: Medicare: 4 Medicaid: 33 Other: 7 Total: 44 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 27, 2025.	F 0000		
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin Huston	Administrator	06/03/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Based on interview and record review, the facility failed to implement their facility abuse prevention program policy when staff members failed to report a suspicion of abuse, involving three cognitively impaired residents, which delayed the initiation of the facility investigation and reporting to the appropriate agencies, for 3 of 5 residents reviewed for abuse. (Resident D, Resident F, DON, LPN 5 and CNA 6) Findings include: During a phone interview on 5/15/25 at 10:40 a.m., LPN 5 indicated she observed Resident D put his hands up Resident G's shirt sleeve and touch her breast. She did not report it at the time of the incident due to it being a weekend. She waited until Tuesday, 5/6/25 at approximately 9:00 p.m., to notify the Director of Nursing (DON) via text of the incident between Resident D and Resident G. She also reported an allegation that Resident F fondled Resident D's groin through his clothing. CNA 6 had reported the fondling to her at the start of her shift on 5/6/25. During a phone interview on 5/15/25 at 1:00 p.m., LPN 5 indicated she witnessed Resident D touching Resident G's breast on 5/3/25, and she did not report it until 5/6/25. The Administrator spoke with her on 5/9/25 regarding Resident D touching Resident G's breast. During a phone interview on 5/15/25 at 10:50 a.m., CNA 6 indicated she had to intervene during an episode, approximately one week prior, when Resident F fondled Resident D's groin through his clothing. Resident F was redirected away from Resident D. Resident F immediately turned around, reapproached Resident D, sat down on his lap, and bounced up and down. CNA 6 immediately intervened and removed Resident F	F 0607	F607 Reporting abuse to the Abuse Coordinator It is the policy of this facility to implement their facility abuse prevention program policy when staff members fail to report a suspicion of abuse, involving cognitively impaired residents and to initiate a facility investigation and reporting to the appropriate agencies. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. DON/Designee assessed resident A and B on 5/15/2025 with no negative outcomes. The MDS Nurse/Designee updated Resident F's behavior care plan regarding sexual behaviors on 5/15/2025. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents had the potential to be affected, therefore, this plan of correction applies to all residents. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. Regional Nurse Consultant educated Administrator and Director of Nursing (DON) on the Abuse Policy, reporting of allegations within 2 hours, and investigating allegations of abuse	06/07/2025

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	from the dining room. LPN 5 and LPN 7 were notified on the day of the incident. She did not report the incident to the DON or the Administrator until 5/7/25. During a phone interview on 5/15/24 at 1:05 p.m., LPN 7 indicated she did not work on 5/6/25 and staff did not report any inappropriate sexual behaviors to her. During an interview on 5/15/24 at 1:40 p.m., the Administrator indicated the DON received a text from LPN 5 on Tuesday, 5/6/25 at 8:39 p.m. The DON did not inform the Administrator of the text until Wednesday, 5/7/25 at 9:00 a.m. during the managers' meeting. The text indicated Resident D had inappropriately touched a female resident. CNA 6 was interviewed on 5/7/25. CNA 6 informed the Administrator that on 5/6/25, a female resident sat down on a male resident's lap and had begun to bounce up and down while sitting on the male resident's lap and CNA 6 might have indicated a male resident was fondled through his clothing. Staff were to report incidents of this type immediately. The DON was unavailable for interview at the time of the survey on 5/14/25 and 5/15/25. Resident D's clinical record was reviewed on 5/14/25 at 11:20 a.m. Diagnoses included dementia in other diseases, classified elsewhere, mild, without behavioral disturbance, encephalopathy (brain disease that alters brain function or structure) and sexual aversion disorder. The most recent Minimum Data Set (MDS) assessment, dated 2/17/25, indicated the resident was moderately cognitively impaired. Behaviors were not exhibited.		per the IDOH reporting guidelines on 5/19/2025. Regional Nurse consultant educated staff on reporting allegations per abuse policy on 5/19/2025. This education included LPN 5 and CNA 6. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Administrator/Designee will interview 20 random staff members on random shifts for any incident/behavior that would require reporting to ISDH and verify staff are reporting timely to the Administrator weekly x 4 weeks, then 10 random staff members weekly x 4 weeks, then 5 random staff members monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator	

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	A current care plan, revised on 5/9/25, indicated Resident D displayed socially inappropriate behavior, such as attempting to hug and hold female residents' hands or touch other body parts and try to get female residents to touch him. The goal indicated the resident to have improvement in socially inappropriate behaviors through next review. The electronic medication administration record indicated behavior monitoring every shift for wandering, depressive symptoms, sexual inappropriateness (attempting to hug female residents/attempting to hold female residents' hands). A progress note, dated 5/7/25, indicated the Director of Nursing (DON) and Administrator educated Resident D on inappropriate touch and holding hands with female residents. The Resident agreed not to have any touch at all with any female residents. Due to staff noticing the female residents showing more attention to Resident D, 15-minute checks were initiated. Continuation of the 15-minute checks was to be reassessed on 5/12/25. A progress note, dated 5/8/25, indicated Resident D was placed on one-on-ones in place of 15-minute checks due to female residents approaching Resident D and wanting their backs scratched. A psychiatric progress note dated 5/14/25 indicated Resident D was seen for inappropriate sexual behavior and gradual dose reduction of Zoloft (an antidepressant medication). Staff had reported the resident had been holding hands and touching certain female residents on the unit.		weekly until resolved. By what date the systemic changes for each deficiency will be complete. 6/07/2025	

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	Reports verbalized by staff had been inconsistent, making the accuracy of Resident D expressing inappropriate sexual behaviors hard to determine. Resident G's clinical record was reviewed on 5/15/25 at 11:30 a.m. Diagnoses included dementia, non-traumatic brain dysfunction, and anemia (deficiency of red blood cells causing reduced oxygen throughout the body). The most recent Minimum Data Set (MDS) assessment, dated 5/1/25, indicated the resident was severely cognitively impaired, had moderate depression, and did not demonstrate behavioral symptoms. 3. Resident F's clinical record was reviewed on 5/15/25 at 11:40 a.m. Diagnoses included unspecified dementia, moderate, with other behavioral disturbance, depression, anxiety, delusional disorder, unspecified dementia, moderate, with agitation, and pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder). The most recent Minimum Data Set (MDS) assessment, dated 4/9/25, indicated the resident was severely cognitively impaired and behavioral symptoms, not directed towards others, occurred daily. The resident's behavior status was identified as worse, compared to prior assessment. An electronic medication administration record, dated May 2025, indicated behavior monitoring every shift for wandering, delusions, insomnia, hallucinations, yelling out, crying, and refusal of care. A psychiatric progress note, dated 5/14/25, indicated Resident F was seen for inappropriate			

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	sexual behaviors, including touching a male resident. Inappropriate sexual behaviors were hard to determine due to inconsistent staff reports. Resident F's clinical record lacked documentation and a care plan regarding sexual behaviors. A current policy, dated 10/22/22, titled "Abuse Prevention Program", provided by the Administrator 5/15/25 at 11:35 a.m., indicated the following: " ...Policy. 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 dash centered environment in which all individuals are treated as human beings. The following procedure shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or an allegation of suspected abuse or neglect of a resident by a third party. Procedure ...II. Orientation and Training of Employees ... staff obligations to prevent and report abuse, neglect, mistreatment any crime against the resident, theft and how to distinguish theft from lost items and willful abuse from insensitive staff actions that should be corrected through counseling and additional training. Staff should report their knowledge of allegations without fear of reprisal ... What constitutes abuse (physical, mental, sexual, verbal), neglect, mistreatment and misappropriation of resident property ...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 will immediately report the allegation to the administrator. The administrator is the abuse coordinator ... supervisor shall immediately inform the administrator or in the absence of the			

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	administrator, the person in charge of the facility of all reports of incidents, allegations or suspicion of potential treatment. Upon learning of the report, the administrator or in the absence of the administrator, the person in charge of the facility shall initiate an incident investigation ...ABUSE REPORTING. Policy ... all personnel must promptly report any incident or suspected incident of resident abuse, mistreatment or neglect, including injuries of unknown origin ...3. Sexual abuse: including, but not limited to, sexual harassment, sexual coercion or sexual assault ...Procedure. Any alleged violations involving mistreatment, abuse, neglect, misappropriation of resident property and any injuries of unknown origin MUST be reported to the administrator and director of nursing. The administrator is the abuse coordinator of the facility. Additionally, the person(s) observing an incident of resident abuse or suspecting resident abuse must IMMEDIATELY report such incidents to the charge nurse, regardless of the time lapse since the incident occurred. The charge nurse will immediately report the incident to the administrator or to the individual in charge of the facility during the administrator's absence ... A completed copy of the incident report and written statements from witnesses, if any, will be provided to the administrator or individual in the charge of the facility within 24 hours of the occurrence of such incident ...." This citation relates to complaint IN00459159. 3.1-28(c)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on record review and interview, the facility	F 0609	F 609 Reporting Violations	06/07/2025

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	failed to report two allegations of sexually-toned abusive behavior between cognitively impaired residents to the appropriate agencies in a timely manner within the required timeframe. (Resident D, Resident F and Resident G) Findings include: During a phone interview on 5/15/25 at 10:40 a.m., LPN 5 indicated she observed Resident D put his hands up Resident G's shirt sleeve and touch her breast. She did not report it to the Administrator at the time of the incident due to it being a weekend. She waited until Tuesday, 5/6/25 at approximately 9:00 p.m., to notify the Director of Nursing (DON) via text of the incident between Resident D and Resident G. She also reported an allegation that Resident F fondled Resident D's groin through his clothing. CNA 6 reported the fondling to her at the start of her shift on 5/6/25. During a phone interview on 5/15/25 at 1:00 p.m., LPN 5 indicated the observation she witnessed was on 5/3/25 and she did not report it until 5/6/25. The Administrator spoke with her on 5/9/25 regarding Resident D touching Resident G's breast. During a phone interview on 5/15/25 at 10:50 a.m., CNA 6 indicated that she had to intervene during an episode, approximately one week prior, when Resident F fondled Resident D's groin through his clothing. Resident F was redirected away from Resident D. Resident F immediately turned around, reapproached Resident D, sat down on his lap, and bounced up and down. CNA 6 immediately intervened and removed Resident F from the dining room. LPN 5 and LPN 7 were notified on the day of the incident. She did not report the incident to the DON or the		It is the policy of this facility to report any form of abuse to the appropriate agencies within the required timeframe. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee assessed residents D, F, and G on 5/15/2025 with no negative outcome. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected. Therefore, this plan of correction applies to all residents. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. Regional Nurse Consultant educated Administrator and Director of Nursing (DON) on the Abuse Policy, reporting of allegations within 2 hours, and investigating allegations of abuse per the IDOH reporting guidelines on 5/19/2025. Regional Nurse consultant educated staff on reporting allegations per abuse policy on 5/19/2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined	

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	Administrator until 5/7/25. During an interview on 5/15/24 at 1:40 p.m., the Administrator indicated the DON received a text from LPN 5 on Tuesday, 5/6/25 at 8:39 p.m. The DON did not inform the Administrator of the text until Wednesday, 5/7/25 at 9:00 a.m. during the managers' meeting. The text identified Resident D had inappropriately touched a female resident. CNA 6 was interviewed on 5/7/25. CNA 6 informed the Administrator that on 5/6/25, a female resident sat down on a male resident's lap and had begun to bounce up and down while sitting on the male resident's lap and CNA 6 might have indicated a male resident was fondled through his clothing. Staff were to report incidents of this type immediately. An email confirmation, dated 5/8/25 and provided by the Administrator on 5/15/24 at 2:26 p.m., indicated an incident was submitted to the Indiana State Department of Health on 5/8/25, 1:48 p.m., and an identified date and time of incident of incident of 5/7/25 at 9:01 a.m. Twenty eight hours and forty-eight minutes lapsed from the time the Administrator became aware of Resident D touching Resident G's breast and the submission of the incident to the Indiana State Department of Health. A current facility policy, dated 10/22/22 and titled "Abuse Prevention Program", provided by the Administrator on 5/15/25 at 11:35 a.m., indicated the following: "...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 ... when an alleged or suspected case of abuse or neglect is reported to the administrator, the administrator, or person in		as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Administrator/Designee will interview 20 random staff members on random shifts for any incident/behavior that would require reporting to ISDH and verify staff are reporting timely to the Administrator weekly x 4 weeks, then 10 random staff members weekly x 4 weeks, then 5 random staff members monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be complete. DATE: 6/07/2025	

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	charge of the facility, will notify the following persons or agencies of such incident immediately ... law enforcement officials as per the policy on reporting reasonable suspicions of a crime in LTC facility... sexual abuse of a resident by a staff member, another resident or visitor...." Cross reference F607. This citation relates to Complaint IN00459159. 3.1-28(c)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on interview and record review, the facility failed to identify and monitor sexual behavior expressions in order to develop and implement individualized interventions for a cognitively impaired resident for 1 of 2 residents reviewed for behavior monitoring. (Resident F) Finding includes: Resident F's clinical record was reviewed on 5/15/25 at 11:40 a.m. Current diagnoses included unspecified dementia, moderate, with other behavioral disturbance, depression, anxiety, delusional disorder, unspecified dementia, moderate, with agitation, and pseudobulbar affect (involuntary laughing and crying due to a nervous system disorder). A 4/9/25, annual, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and behavioral symptoms that were not directed towards others occurred daily. The resident's behavior status was identified as worse, compared to the prior	F 0744	F744 – Treatment/Services for Dementia It is the policy of this facility to identify and monitor sexual behavior expression in order to develop and implement individualized interventions for cognitively impaired residents. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The DON/Designee updated Resident F's behaviors monitoring to include sexual behaviors on 5/15/2025. The MDS/Designee updated Resident F's care plan for sexual behaviors and individualized interventions on 5/15/2025. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective	06/07/2025

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	assessment. A current care plan, dated 4/8/24, indicated Resident F was at risk for behavioral disturbances related to diagnosis of dementia with behavioral disturbances and history of behaviors with need for anti-psych medications. Interventions included notifying physician, family, and interdisciplinary team (IDT) of changes in behaviors, observe for behaviors, monitor for effectiveness of meds and interventions. A current care plan, dated 8/5/24, indicated Resident F had a diagnosis of dementia and has been noted to have episodes of yelling out and crying and is not able to identify wants and needs when asked. Interventions included to update physician, family, and psychiatric nurse practitioner (NP) as needed, approach the resident in calm manner, redirect the resident to activities of interest, such as going outside or listening to music. A current care plan, dated 5/12/23, indicated Resident F had a diagnosis of dementia with short term and long term memory impairment and a diagnosis of dementia, moderate, with other behavioral disturbances. Interventions included antidementia medications per order, notify MD and family as needed, redirect the resident to activities of interest, such as going outside or listening to music, and repeat self as needed. A Psychiatry Progress Note, dated 5/14/25, indicated Resident F was seen for inappropriate sexual behaviors, including touching a male resident. Inappropriate sexual behaviors were difficult to determine due to inconsistent staff reports.		action will be taken? The DON/Designee completed and audit of resident's behavior monitoring orders and updated monitoring as indicated on 5/15/2025. The MDS nurse/Designee completed an audit of residents behavior care plans and updated with individualized interventions as indicated on 5/23/2025. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Regional Nurse Consultant and Regional MDS Consultant in-serviced Social Services and DON on identifying and monitoring behaviors in order to develop care with individualized interventions for cognitively impaired residents on 5/21/2025. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How will the corrective action be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place? The SSD/Designee will audit 10 resident care plans weekly for four weeks, then 5 residents weekly for four weeks, then 3 residents weekly x four months for care plan with individualized interventions for behaviors. The DON/Designee will audit 10	

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	The electronic medication administration record, dated May 2025, indicated behavior monitoring every shift for wandering, delusions, insomnia, hallucinations, yelling out, crying, and refusal of care. The clinical record lacked a plan of care related to sexual behavior expressions, including behavior monitoring related to sexually-toned behaviors. During a phone interview on 5/15/25 at 10:50 a.m., CNA 6 indicated that she had to intervene during an episode, approximately one week prior, when Resident F fondled Resident D's groin through his clothing. Resident F was redirected away from Resident D. Resident F immediately turned around, reapproached Resident D, sat down on his lap, and bounced up and down. She immediately intervened and removed Resident F from the dining room. LPN 5 and LPN 7 were notified on the day of the incident. She did not report the incident to the Director of Nursing (DON) nor the Administrator. During an interview on 5/15/25 at 1:40 p.m., the Corporate RN indicated that Resident F's inappropriate behaviors of touching, sitting on a male resident's lap, and bouncing on a male resident's lap should have been care planned and these behaviors should have been monitored. She confirmed there was a lack of documentation regarding inappropriate sexual behaviors in Resident F's record, including a care plan. During an interview on 5/15/25 at 1:40 p.m., the Administrator indicated the facility planned to move Resident D from the secured unit, but this would not resolve Resident F's inappropriate sexual behaviors. Staff should have reported the incident immediately. The Administrator		residents' behavior monitoring orders weekly x 4 weeks, then 5 residents weekly x 4 weeks, then 3 residents weekly x 4 months for behaviors and update monitoring with new behaviors as needed. The DON/Designee will audit 24 hour report for new behaviors daily x 4 weeks, 3 times weekly x 4 weeks, then weekly x 4 months for new behaviors and update orders as needed. Results will be forwarded to QAPI committee for further recommendations and resolution as necessary. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date will the systemic changes for each deficiency be completed? 6/07/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 00 B. WING	05/15/2025

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	confirmed there was a lack of documentation regarding inappropriate sexual behaviors in Resident F's record, including a care plan. During an interview on 5/15/25 at 1:49 p.m., the Social Services Director (SSD) indicated she was made aware of Resident F's inappropriate sexual behaviors at the manager's meeting on 5/7/25 at 9:00 a.m. She felt Resident F's increased behaviors were due to the dynamics of the secured unit having changed due to new residents being admitted to the unit. Resident F sought attention from resident D and did not want other residents to gain his attention. Upon hearing about Resident F's sexually toned behavior with Resident D, the facility immediately put interventions in place for Resident D. Nursing interventions, such as increased surveillance, were implemented but not documented. She confirmed there was a lack of documentation regarding inappropriate sexual behaviors in Resident F's record, including a care plan. A current facility policy, updated 11/25/17, titled "Baseline Care Plan Assessment/Comprehensive Care Plans", provided by the Administrator on 5/15/25 at 3:25 p.m., indicated the following: "Policy:..The Comprehensive Care Plan will further expand on the resident's risks, goals, and interventions using the "Person-Centered" Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs ...Procedure:..9. The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues ...."			

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	A current facility, dated 3/18/23, titled "GUIDELINES FOR HANDLING AND ADDRESSUING BEHAVIORAL EMERGENCIES", provided by the Administrator on 5/15/25 at 3:25 p.m., indicated the following: "I. The First Step Involves Recognizing and Handling the Behavior in the Earliest Stages ...II. The Escalating Resident ...B. Immediate Approaches ...11. Every resident behavior will be assessed and addressed individually. There is no Standing Program for behavior management. C. Documentation 1. Record specifics related to the behavior incident(s). Include time, place, duration, actions observed by the resident, statements or vocalizations made by the resident, positive causative factors, persons involved other than resident, witnesses, behavior intensity, interventions, notifications, orders received and resolutions. This documentation should be done on a behavioral occurrence form for the review at the CQI meeting and slash or the Behavior Meetings. 2. Documentation in the clinical record should include facts related to time, positive causative factors, actual behavior with consequences, interventions and outcomes. Three. An incident report will be completed according to facility policy for any physical altercation or outcome of the behavioral episode that results in meeting state reportable criteria. The protocol for reporting to the state as per state guidelines and facility policy will be followed ...III. Provide On-Going Training in Crisis Management and Prevention ...F. Be sure that the assessments and care planning and medication reviews as well as the individualized Activity Programs for residents with behavior issues are done accurately and timely." This citation relates to complaint IN00459159.			

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