STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155443	A. BU B. WI	JILDING ING	00	COMPL 05/15/		
		100110	2		ADDRESS, CITY, STATE, ZIP COD	00/10/	2020	
NAME OF F	PROVIDER OR SUPPLIER	1			HATEAU DR			
WATERS	OF MUNCIE, THE				E, IN 47303			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG F 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFERRET		DATE	
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		F 00	000				
	accordance with 410	reflect State Findings cited in						
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii) Develop/Implemer	)(iii) nt Abuse/Neglect Policies						

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

Robin Huston Administrator 06/03/2025

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/15/2025		
	OF PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303				
(X4) II PREFI TAC	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Based on interview failed to implement program policy whereport a suspicion of cognitively impaired initiation of the fact to the appropriate as reviewed for abuse DON, LPN 5 and Cognitively impaired initiation of the fact to the appropriate as reviewed for abuse DON, LPN 5 and Cognitively include:  During a phone into LPN 5 indicated she hands up Resident of the until Tuesday, 5/6/2 notify the Director the incident between She also reported a fondled Resident Douring a phone into LPN 5 indicated she touching Resident of the did not report it until spoke with her on 5 touching Resident Conditions approximate Resident Fondled clothing. Resident Resident Douring Resident Douring Resident Resident Douring Resident Resident Douring Resident Resident Douring Resident Douring Resident Resident Douring Resident Dour	and record review, the facility their facility abuse prevention en staff members failed to of abuse, involving three addresidents, which delayed the fility investigation and reporting gencies, for 3 of 5 residents. (Resident D, Resident F, ENA 6)  erview on 5/15/25 at 10:40 a.m., to observed Resident D put his G's shirt sleeve and touch her report it at the time of the eing a weekend. She waited 25 at approximately 9:00 p.m., to of Nursing (DON) via text of an Resident D and Resident G. In allegation that Resident F is groin through his clothing. It did the fondling to her at the 5/6/25.  erview on 5/15/25 at 1:00 p.m., to of Sis breast on 5/3/25, and she iil 5/6/25. The Administrator is/9/25 regarding Resident D	F 00		F607 Reporting abuse to the Abuse Coordinator It is the policy of this facility to implement their facility abuse prevention program policy who staff members fail to report a suspicion of abuse, involving cognitively impaired residents to initiate a facility investigatio and reporting to the appropriat agencies.  What corrective action will be accomplished for those reside found to have been affected by deficient practice.  DON/Designee assessed resided and B on 5/15/2025 with not negative outcomes.  The MDS Nurse/Designee upon Resident F's behavior care plategarding 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 be affected, therefore, this plate correction applies to all reside What measures will be put in place and what systemic chant will be made to ensure that the deficient practice does not recovered the resident practice does not recove	and note nts y the dent dated an of nts. ges e ur.	06/07/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	LDING	00	COMPLE	
		155443	B. WIN	√G		05/15/2	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIE	R		2400 CI	HATEAU DR		
WATERS	S OF MUNCIE, THE	<u> </u>		MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		om. LPN 5 and LPN 7 were			per the IDOH reporting guidel	ines	
		of the incident. She did not			on 5/19/2025.		
	report the incident						
	Administrator until	1 5/7/25.			Regional Nurse consultant		
					educated staff on reporting		
		erview on 5/15/24 at 1:05 p.m.,			allegations per abuse policy o	n	
		ne did not work on 5/6/25 and			5/19/2025. This education		
	-	any inappropriate sexual			included LPN 5 and CNA 6.		
	behaviors to her.				Additionally, any staff membe	r	
					that fails to comply with the po	oints	
	During an interview on 5/15/24 at 1:40 p.m., the				of this in-service will be furthe	r	
	Administrator indic	cated the DON received a text			educated and/or disciplined as	s	
	from LPN 5 on Tue	esday, 5/6/25 at 8:39 p.m. The			indicated.		
	DON did not inform	m the Administrator of the text			How the corrective action will	be	
	until Wednesday, 5	5/7/25 at 9:00 a.m. during the			monitored to ensure the defici	ent	
	managers' meeting.	. The text indicated Resident D			practice will not recur, i.e., wh	at	
	had inappropriately	y touched a female resident.			quality assurance program wil	ll be	
	CNA 6 was intervi	ewed on 5/7/25. CNA 6			put into place.		
	informed the Admi	inistrator that on 5/6/25, a			The Administrator/Designee w	vill	
	female resident sat	down on a male resident's lap			interview 20 random staff mer	mbers	
	and had begun to b	ounce up and down while			on random shifts for any		
	sitting on the male	resident's lap and CNA 6 might			incident/behavior that would		
	have indicated a ma	ale resident was fondled			require reporting to ISDH and	verify	
	through his clothin	g. Staff were to report			staff are reporting timely to the	e	
	incidents of this typ	pe immediately.			Administrator weekly x 4 weel	ks,	
					then 10 random staff member	s	
		vailable for interview at the time			weekly x 4 weeks, then 5 rand	dom	
	of the survey on 5/	14/25 and 5/15/25.			staff members monthly x 4		
					months. If the facility is within	n	
	Resident D's clinic	al record was reviewed on			95% compliance at the end of	the	
	5/14/25 at 11:20 a.:	m. Diagnoses included dementia			6 months; then monitoring car	n be	
	in other diseases, c	lassified elsewhere, mild,			stopped. Results of the monitor	oring	
	without behavioral disturbance, encephalopathy				will be reviewed at the monthl	y	
	(brain disease that alters brain function or				QAPI meeting. Any concerns	will	
	structure) and sexual aversion disorder.				have been addressed. Howev	er,	
	, in the second of the second				any patterns will be identified.	Any	
	The most recent Minimum Data Set (MDS)				needed Action Plan will be wr	- 1	
	assessment, dated 2	2/17/25, indicated the resident			by the QAPI committee. Any		
		gnitively impaired. Behaviors			written Action Plan will be		
	were not exhibited.				monitored by the Administrato	or	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  05/15/2025	
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD CHATEAU DR IE, IN 47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Resident D displays behavior, such as at female residents' ha and try to get femal goal indicated the re	revised on 5/9/25, indicated ed socially inappropriate tempting to hug and hold ands or touch other body parts to residents to touch him. The esident to have improvement wriate behaviors through next		weekly until resolved. By what date the systemic changes for each deficiency be complete. 6/07/2025	will
	indicated behavior in wandering, depress inappropriateness (a	ication administration record monitoring every shift for ive symptoms, sexual attempting to hug female g to hold female residents'			
	Director of Nursing educated Resident I holding hands with Resident agreed not any female resident female residents she Resident D, 15-min	ted 5/7/25, indicated the (DON) and Administrator D on inappropriate touch and female residents. The to have any touch at all with s. Due to staff noticing the owing more attention to ute checks were initiated.  15-minute checks was to be 25.			
	D was placed on on 15-minute checks d	ted 5/8/25, indicated Resident e-on-ones in place of ue to female residents ent D and wanting their backs			
	indicated Resident I sexual behavior and Zoloft (an antidepre reported the residen	ess note dated 5/14/25 D was seen for inappropriate I gradual dose reduction of essant medication). Staff had thad been holding hands and male residents on the unit.			

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE O	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155443	B. WING		05/15/2025	
		l	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	2		CHATEAU DR		
WATERS	OF MUNCIE, THE	:		CIE, IN 47303		
WATERC	OI WONOIL, THE	-	WONC			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	by staff had been inconsistent,				
	-	y of Resident D expressing				
	inappropriate sexua	l behaviors hard to determine.				
		al record was reviewed on				
	5/15/25 at 11:30 a.m. Diagnoses included dementia,					
		dysfunction, and anemia				
		lood cells causing reduced				
	oxygen throughout	the body).				
	TTI	D. C. (AFDC)				
		nimum Data Set (MDS)				
		/1/25, indicated the resident				
		tively impaired, had moderate				
	-	not demonstrate behavioral				
	symptoms.					
	2 Danidan4 Fla alini	1				
		ical record was reviewed on				
		m. Diagnoses included				
	-	ia, moderate, with other				
		nce, depression, anxiety,				
		unspecified dementia,				
		ation, and pseudobulbar affect				
	` ** *	luntary laughing and crying				
	due to a nervous sy	stem disorder).				
	The most recent M:	nimum Data Set (MDS)				
		/9/25, indicated the resident				
		tively impaired and behavioral				
		cted towards others, occurred				
		s behavior status was				
		compared to prior assessment.				
	identified as worse,	compared to prior assessment.				
	An electronic medic	cation administration record,				
		dicated behavior monitoring				
		dering, delusions, insomnia,				
	-					
	hallucinations, yelling out, crying, and refusal of care.					
	care.					
	A psychiatric progr	ess note, dated 5/14/25,				
		F was seen for inappropriate				
	maicated Resident	was seen for mappropriate	1			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155443	r í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 05/15/	ETED
	PROVIDER OR SUPPLIER			2400 CH	ADDRESS, CITY, STATE, ZIP COD HATEAU DR E, IN 47303		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL ALSO DEPOTITE VINC DIFFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG	sexual behaviors, ir resident. Inappropri	acluding touching a male late sexual behaviors were hard inconsistent staff reports.		TAG	BEIGHNET		DATE
		l record lacked documentation arding sexual behaviors.					
	Prevention Program	ated 10/22/22, titled "Abuse n", provided by the /25 at 11:35 a.m., indicated the					
	following: "Polic to prevent resident	ey. It is the policy of this facility abuse, neglect, mistreatment					
	resident receives ca	on of resident property. Each re and services in a person onment in which all					
	following procedure	ted as human beings. The e shall be implemented when nt becomes aware of abuse or					
	neglect of a residen abuse or neglect of	t, or an allegation of suspected a resident by a third party.					
	Employees staff	entation and Training of obligations to prevent and ot, mistreatment any crime					
	theft from lost item	, theft and how to distinguish s and willful abuse from ions that should be corrected					
	through counseling	and additional training. Staff knowledge of allegations					
	(physical, mental, s	isal What constitutes abuse exual, verbal), neglect, hisappropriation of resident					
	propertyIV. Iden	tification. Employees are ny incident, allegation or					
	mistreatment they o	al abuse, neglect or					
	will immediately re	or an immediate supervisor sport the allegation to the administrator is the abuse					
	-	rvisor shall immediately inform in the absence of the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/15/2025	
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	P	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	erson in charge of the facility					
	_	idents, allegations or suspicion					
	•	ent. 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 investigationABUSE REPORTING. Policy all personnel must						
		v incident or suspected					
		abuse, mistreatment or					
		njuries of unknown origin3.					
Sexual abuse: including, but not limited to, sexual harassment, sexual coercion or sexual assaultProcedure. Any alleged violations involving							
mistreatment, abuse, neglect, misappropriation of							
		nd any injuries of unknown					
	-	ported to the administrator and					
	_	The administrator is the abuse					
		acility. Additionally, the					
		g an incident of resident abuse					
	or suspecting reside						
		eport such incidents to the					
		dless of the time lapse since ed. The charge nurse will					
	immediately report						
		the individual in charge of the					
		idministrator's absence A					
		the incident report and written					
		tnesses, if any, will be provided					
		or individual in the charge of					
		4 hours of the occurrence of					
	such incident"	Thous of the occurrence of					
	such meracit						
	This citation relates	s to complaint IN00459159.					
	3.1-28(c)						
F 0609 SS=D	483.12(b)(5)(i)(A)(Reporting of Alleg						
Bldg. 00	Based on record rev	view and interview, the facility	F 060	09	F 609 Reporting Violations		06/07/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY  COMPLETED  05/15/2025	
	PROVIDER OR SUPPLIER		2400 0	ADDRESS, CITY, STATE, ZIP COD CHATEAU DR CIE, IN 47303	•
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG		allegations of sexually-toned	TAG	DEFICIENCY)	DATE
	-	etween cognitively impaired		It is the policy of this facility to report any form of abuse to the	
		ropriate agencies in a timely		appropriate agencies within the	
	manner within the required timeframe. (Resident D,			required timeframe.	
	Resident F and Resident G)			What corrective action will be	
	resident i una res	racin G)		accomplished for those reside	
	Findings include:			found to have been affected by	
	i mamgs merade.			deficient practice.	by the
	During a phone inte	erview on 5/15/25 at 10:40 a.m.,		The DON/Designee assessed	۱
	~ .	e observed Resident D put his		residents D, F, and G on	1
		G's shirt sleeve and touch her		5/15/2025 with no negative	
	-			outcome.	
	breast. She did not report it to the Administrator at the time of the incident due to it being a			How other residents having the	ne
		ed until Tuesday, 5/6/25 at		potential to be affected by the	
		p.m., to notify the Director of		same deficient practice will be	
		text of the incident between		identified and what corrective	
		ident G. She also reported an		action will be taken.	
		dent F fondled Resident D's		All residents have the potential	al to
	-	othing. CNA 6 reported the		be affected. Therefore, this p	
		the start of her shift on 5/6/25.		correction applies to all reside	
	8			What measures will be put in	
	During a phone inte	erview on 5/15/25 at 1:00 p.m.,		place and what systemic chair	
		e observation she witnessed		will be made to ensure that th	_
		the did not report it until		deficient practice does not re	
		strator spoke with her on		Regional Nurse Consultant	
		esident D touching Resident G's		educated Administrator and	
	breast.	<u> </u>		Director of Nursing (DON) on	the
				Abuse Policy, reporting of	
	During a phone inte	erview on 5/15/25 at 10:50 a.m.,		allegations within 2 hours, an	d
	CNA 6 indicated th	at she had to intervene during		investigating allegations of ab	
	an episode, approxi	mately one week prior, when		per the IDOH reporting guide	
	Resident F fondled	Resident D's groin through his		on 5/19/2025.	
	clothing. Resident I	was redirected away from			
		nt F immediately turned		Regional Nurse consultant	
		ed Resident D, sat down on		educated staff on reporting	
	his lap, and bounced up and down. CNA 6			allegations per abuse policy of	on
	immediately intervened and removed Resident F			5/19/2025. Additionally, any s	staff
	_	m. LPN 5 and LPN 7 were		member that fails to comply v	vith
	-	of the incident. She did not		the points of this in-service w	ill be
	report the incident t	o the DON or the		further educated and/or discip	olined

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NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  (X5) ID  REGULATORY OR ISE DIRECTIVING INFORMATION  Administrator until 57/25.  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 sad down on a male resident system and had begun to bounce up and down while sitting on the male resident's lap and LRA 6 might have indicated an aller esident's stopated 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 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 Gs breast and the submission of the incident to the Indiana State Department of Health.  A current facility policy, dared 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 (RS) will	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155443		 UILDING	onstruction 00	(X3) DATE COMPI <b>05/15</b>	ETED	
PREFIX TAG REGULATORY OR LSCIDENTIFYING INFORMATION  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's lap and had begun to bounce up and down while sitting on the 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 on 5/8/25 and provided with the 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 of 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				2400 CI	HATEAU DR		
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, 5/6/25 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 stap 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	PREFIX	(EACH DEFICIEN REGULATORY OF	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
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		During an interview Administrator indicated an incident State Department of and incident of the incident to the Health.  A current facility per "Abuse Prevention Administrator on 56 the following: "Tutilizing the incident system of Department of Healts suspected case of all and interview."	on 5/15/24 at 1:40 p.m., the atted the DON received a text isday, 5/6/25 at 8:39 p.m. The in the Administrator of the text identified Resident D touched a female resident. Sewed on 5/7/25. CNA 6 instrator that on 5/6/25, a down on a male resident's lap bounce up and down while resident's lap and CNA 6 might alle resident was fondled g. Staff were to report in immediately.  Staff were to report in immediately.  The twas submitted to the Indiana of Health on 5/8/25, 1:48 p.m., at was submitted to the Indiana of Health on 5/8/25, 1:48 p.m., at and time of incident of the 19:01 a.m. Twenty eight hours utes lapsed from the time the immediate aware of Resident D G's breast and the submission in the Indiana State Department of the Indiana State Department of the Administrator or designee and the Administrator or designee and the Administrator or designee and the Indiana State Department of Indiana State Indiana Indi		How the corrective action will monitored to ensure the defici practice will not recur, i.e., wh quality assurance program will put into place.  The Administrator/Designee winterview 20 random staff mer on random shifts for any incident/behavior that would require reporting to ISDH and staff are reporting timely to the Administrator weekly x 4 week then 10 random staff member weekly x 4 weeks, then 5 rand staff members monthly x 4 months. If the facility is within 95% compliance at the end of 6 months; then monitoring car stopped. Results of the monitor will be reviewed at the monthl QAPI meeting. Any concerns have been addressed. However any patterns will be identified. In needed Action Plan will be monitored by the Administrator weekly until resolved.  By what date the systemic changes for each deficiency will be complete.	ent at I be vill nbers verify exs, s dom the pring y will er, Any tten	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	LETED
		155443	B. W	ING		05/15	/2025
						<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	OF MUNICIPATURE				HATEAU DR		
WATERS	S OF MUNCIE, THE	<u>:</u>		MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	charge of the facilit	y, will notify the following					
	persons or agencies	of such incident immediately					
	law enforcement	officials as per the policy on					
	reporting reasonable	e suspicions of a crime in LTC					
	facility sexual abu	use of a resident by a staff					
	member, another re	sident or visitor"					
	Cross reference F60	07.					
	This citation relates	to Complaint IN00459159.					
	3.1-28(c)						
F 0744	483.40(b)(3)						
SS=D	Treatment/Service	e for Dementia					
Bldg. 00							
		and record review, the facility	F 0'	744	F744 – Treatment/Services fo	r	06/07/2025
		d monitor sexual behavior			Dementia		
	_	r to develop and implement			It is the policy of this facility to		
		ventions for a cognitively			identify and monitor sexual		
	_	or 1 of 2 residents reviewed for			behavior expression in order t	0	
	behavior monitoring	g. (Resident F)			develop and implement		
	F2' 1' ' 1 1				individualized interventions for		
	Finding includes:				cognitively impaired residents		
	B 11 . E 11 1				What corrective action will be		
		l record was reviewed on			accomplished for those reside		
		m. Current diagnoses included			found to have been affected b	y the	
		ia, moderate, with other			deficient practice?		
		nce, depression, anxiety,			The DON/Designee updated		
		unspecified dementia,			Resident F's behaviors monito	•	
		ation, and pseudobulbar affect			to include sexual behaviors or	1	
	,	ng and crying due to a			5/15/2025.		
	nervous system disc	order).			The MDS/Designee updated		
	A 4/0/25	4::			Resident F's care plan for sex	ual	
		finimum Data Set (MDS)			behaviors and individualized		
		d the resident was severely			interventions on 5/15/2025.	41	
		d and behavioral symptoms			How will other residents havin	•	
		ed towards others occurred			potential to be affected by the		
		s behavior status was			same deficient practice be		
	identified as worse,	compared to the prior	1		identified and what corrective		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/15/2025 155443 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2400 CHATEAU DR WATERS OF MUNCIE, THE MUNCIE, IN 47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE assessment. action will be taken? The DON/Designee completed and A current care plan, dated 4/8/24, indicated audit of resident's behavior Resident F was at risk for behavioral disturbances monitoring orders and updated related to diagnosis of dementia with behavioral monitoring as indicated on disturbances and history of behaviors with need 5/15/2025. for anti-psych medications. Interventions The MDS nurse/Designee included notifying physician, family, and completed an audit of residents interdisciplinary team (IDT) of changes in behavior care plans and updated behaviors, observe for behaviors, monitor for with individualized interventions as effectiveness of meds and interventions. indicated on 5/23/2025. What measures will be put into A current care plan, dated 8/5/24, indicated place and what systemic changes Resident F had a diagnosis of dementia and has will be made to ensure that the been noted to have episodes of yelling out and deficient practice does not recur? crying and is not able to identify wants and needs The Regional Nurse Consultant when asked. Interventions included to update and Regional MDS Consultant physician, family, and psychiatric nurse in-serviced Social Services and practitioner (NP) as needed, approach the resident DON on identifying and monitoring in calm manner, redirect the resident to activities behaviors in order to develop care of interest, such as going outside or listening to with individualized interventions music. for cognitively impaired residents on 5/21/2025. Additionally, any A current care plan, dated 5/12/23, indicated staff that fails to comply with the Resident F had a diagnosis of dementia with short points of this in-service will be term and long term memory impairment and a further educated and/or disciplined diagnosis of dementia, moderate, with other as indicated. behavioral disturbances. Interventions included How will the corrective action be antidementia medications per order, notify MD monitored to ensure the deficient and family as needed, redirect the resident to practice will not recure, i.e., what activities of interest, such as going outside or quality assurance program will be listening to music, and repeat self as needed. put into place? The SSD/Designee will audit 10 A Psychiatry Progress Note, dated 5/14/25, resident care plans weekly for four indicated Resident F was seen for inappropriate weeks, then 5 residents weekly for sexual behaviors, including touching a male four weeks, then 3 residents resident. Inappropriate sexual behaviors were weekly x four months for care plan difficult to determine due to inconsistent staff with individualized interventions for reports. behaviors. The DON/Designee will audit 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155443	B. W	NG		05/15/	/2025
		<u> </u>		CTDEET A	ADDRESS CITY STATE 7ID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD HATEAU DR		
\\\\\ TED6	COEMINOLE THE	•					
WATERS	OF MUNCIE, THE	: 		MONCH	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ication administration record,			residents' behavior monitoring	l	
	dated May 2025, in	dicated behavior monitoring			orders weekly x 4 weeks, ther	ı 5	
	every shift for wandering, delusions, insomnia,				residents weekly x 4 weeks, th	nen	
	hallucinations, yelling out, crying, and refusal of				3 residents weekly x 4 months	for	
	care.				behaviors and update monitor	ing	
					with new behaviors as needed	d.	
	The clinical record lacked a plan of care related to				The DON/Designee will audit:	24	
	-	pressions, including behavior			hour report for new behaviors	daily	
	monitoring related t	to sexually-toned behaviors.			x 4 weeks, 3 times weekly x 4		
					weeks, then weekly x 4 month	ıs	
	During a phone inte	erview on 5/15/25 at 10:50 a.m.,			for new behaviors and update		
	CNA 6 indicated that she had to intervene during				orders as needed.		
		mately one week prior, when			Results will be forwarded to Q	API	
	Resident F fondled	Resident D's groin through his			committee for further		
	clothing. Resident I	was redirected away from			recommendations and resolut	ion	
	Resident D. Residen	nt F immediately turned			as necessary. If the facility is		
	around, reapproach	ed Resident D, sat down on			within 95% compliance at the	end	
	his lap, and bounce	d up and down. She			of the 6 months; then monitori	ng	
	immediately interve	ened and removed Resident F			can be stopped. Results of the	9	
	from the dining roo	m. LPN 5 and LPN 7 were			monitoring will be reviewed at	the	
	notified on the day	of the incident. She did not			monthly QAPI meeting. Any		
	report the incident t	to the Director of Nursing			concerns will have been		
	(DON) nor the Adn	ninistrator.			addressed. However, any patt	erns	
					will be identified. Any needed		
		on 5/15/25 at 1:40 p.m., the			Action Plan will be written by t	he	
	*	ated that Resident F's			QAPI committee. Any written		
		viors of touching, sitting on a			Action Plan will be monitored	by	
	-	and bouncing on a male			the Administrator weekly until		
	-	d have been care planned and			resolved.		
		uld have been monitored. She			By what date will the systemic		
		s a lack of documentation			changes for each deficiency b	е	
		riate sexual behaviors in			completed? 6/07/2025		
	Resident F's record,	, including a care plan.					
	During an interview	on 5/15/25 at 1:40 p.m., the					
	-	ated the facility planned to					
		om the secured unit, but this					
		Resident F's inappropriate					
		taff should have reported the					
		ly The Administrator					

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155443		 JILDING	00	COMPL 05/15/	ETED	
	PROVIDER OR SUPPLIER		2400 CH	DDRESS, CITY, STATE, ZIP COD HATEAU DR E, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTIC  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROL  TAG DEFICIENCY)		ΓE	(X5) COMPLETION DATE
TAU	confirmed there was regarding inappropr	s a lack of documentation iate sexual behaviors in including a care plan.	TAG			DAIL
	Social Services Dire made aware of Resi behaviors at the man 9:00 a.m. She felt R were due to the dyn having changed due admitted to the unit from resident D and to gain his attention Resident F's sexuall Resident D, the faci interventions in place interventions, such a were implemented by confirmed there was regarding inappropri	con 5/15/25 at 1:49 p.m., the ector (SSD) indicated she was dent F's inappropriate sexual mager's meeting on 5/7/25 at esident F's increased behaviors amics of the secured unit to new residents being Resident F sought attention did not want other residents. Upon hearing about y toned behavior with lity immediately put be for Resident D. Nursing as increased surveillance, but not documented. She is a lack of documentation interested in including a care plan.				
	"Baseline Care Plan Care Plans", provide 5/15/25 at 3:25 p.m. "Policy:The Comp expand on the reside interventions using Care approach for e measurable objective resident's medical, remental and psychose The Comprehensive and updated every of	wly developed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155443	(X2) MULTIPLE CO A. BUILDING B. WING	BUILDING <u>00</u> C		O5/15/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	ADDRESSUING Be provided by the Adp.m., indicated the involves Recognizing in the Earliest StageB. Immediate Apple behavior will be assindividually. There behavior management Record specifics religional includes observed by the restocalizations made causative factors, peresident, witnesses, interventions, notifit resolutions. This do on a behavioral occurrence the CQI meeting and Meetings. 2. Documents and include facts causative factors, acconsequences, intermediate according to facility altercation or outcouthat results in meeting the protocol for reguidelines and facil Provide On-Going and PreventionF. and care planning a as the individualize residents with behavior and time accurately and times.	R HANDLING AND BEHAVIORAL EMERGENCIES", ministrator on 5/15/25 at 3:25 following: "I. The First Steping and Handling the Behavior isII. The Escalating Resident proaches11. Every resident proaches and addressed is no Standing Program for the entation 1. The statements or time, place, duration, actions ident, statements or by the resident, positive ersons involved other than behavior intensity, cations, orders received and cumentation should be done the entation in the clinical record is related to time, positive extual behavior with eventions and outcomes. The report will be completed a policy for any physical me of the behavioral episode ing state reportable criteria. The policy will be followedIII. Event in the clinical review as well defeated to review as well defeated to review as well defeated to review are done.						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155443	B. WING			05/15/2025	
NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE			STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	3.1-37(a)						

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