

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/20/2025
NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on March 31, 2025. This visit included a PSR to the Investigation of Complaint IN00455668 completed on March 31, 2025.</p> <p>This visit was in conjunction with a PSR to the Investigation of Complaint IN00459159 completed on May 15, 2025.</p> <p>This visit was in conjunction with a PSR to the Investigation of Complaint IN00455065 completed on March 11, 2025.</p> <p>Complaint IN00455668 - Corrected.</p> <p>Complaint IN00459159 - Corrected.</p> <p>Complaint IN00455065 - Corrected.</p> <p>Survey date: June 20, 2025</p> <p>Facility number: 000310 Provider number: 155443 AIM number: 100288970</p> <p>Census Bed Type: SNF/NF: 43 Total: 43</p> <p>Census Payor Type: Medicare: 2 Medicaid: 26 Other: 15 Total: 43</p> <p>The Waters of Muncie was found to be in</p>	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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{F 000}	Continued From page 1 compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaint IN00455668. Quality review completed June 24, 2025.	{F 000}			