(X4) ID PREFIX (EAC	ILLAGE SUMMARY STATEMENT (220 MU			
PREFIX (EAC TAG REGU	H DEFICIENCY MUST BE	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		street address, city, state, zip cod 2200 WEST WHITE RIVER BLVD MUNCIE, IN 47303		
		YING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE AI	OULD BE	(X5) COMPLETION DATE
IN00447 Complair related to and F610 Survey de Facility in Provider AIM nur Census Ef SNF/NF Total: 62 Census Ef Medicaid Other: 2 Total: 62	nt IN00447929 - Feder of the allegations are cited. ates: December 9 & 10 number: 000013 number: 155038 nber: 100266100 Bed Type: 62 Payor Type: 1: 60	al/state deficiencies d at F550, F609	F 0000	I wish to request a Des Review/Paper Complia		
F 0550 SS=D Bldg. 00 Based or failed to assist hir bathroon following residents	Resident Rights/Exercise of Rights		F 0550	F550 Neither signing nor sub this plan of correction s constitute an admission deficiency or of any fac conclusion set forth in t "Statement of Deficiency	hall n of any t or he	01/03/2025

James Thomas **Executive Director**

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZTOD11 Facility ID: If continuation sheet

01/03/2025

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED	
		155038	B. W	ING		12/10/	2024	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			VEST WHITE RIVER BLVD			
WATERS	S EDGE VILLAGE				IE, IN 47303			
	1				,			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		endent, vulnerable person			This plan of correction is provi			
		nemselves could experience			as evidence of the facility's de			
		xiety when the facility staff			to comply with the regulations			
		during a vulnerable episode			to continue to provide quality	care.		
		ere he was found to be						
	_	covered in feces, seated on a			what corrective action(s)	Will		
	bathroom floor with staff closing the door.				be accomplished for those			
	F' 1' ' 1 1				residents found to have been			
	Findings include:				affected by the deficient practi	ice;		
	1	'4 4 1 1' D 4 4 C			Resident C has been			
	A complaint filed with the Indiana Department of				observed since the incident ar			
	Health indicated Resident C had been in a bathroom, alone, with his door shut and was				has had no episodes of fear o			
					anxiety related to the incident	on		
	unable to open doors due to his diagnoses.				11/21/24.			
	Resident C's clinical record was reviewed on				how other residents havi	na		
		n. Diagnoses included dementia,			the potential to be affected by	-		
		tic disorder with delusions,			same deficient practice will be			
		ystonia, and history of alcohol			identified and what corrective			
	abuse.	, 51011111, 4114 1115101 , 61 414 61161			action(s) will be taken;			
					All residents on the			
	A quarterly Minim	ım Data Set (MDS)			Dementia care unit have the			
		1/19/24, indicated the resident			potential to be affected. Howe	ver		
		e impairment, required			no other residents were found			
	_	l assistance with eating and			be affected.			
		taff for toileting, oral hygiene,			A Nursing staff inservice	was		
	bathing, dressing, n	nobility, and transfers. The			conducted on resident rights v			
	resident was able to	ambulate with supervision			an emphasis on dignity and			
	and touching assists	ance.			incontinent care.			
	A current care plan	, dated 9/11/23, indicated			what measures will be pเ	ıt 💮		
	_	l assistance with toileting due			into place or what systemic			
		powel and bladder, impaired			changes will be made to ensu			
		tial to play in his own feces at			that the deficient practice does	s not		
		s included, (10/8/24) resident's			recur;	ļ		
		wished for his dignity to be			All nursing staff inservice			
		n as possible during times of			was conducted on resident rig			
		allow privacy by guiding him			with an emphasis on dignity a	nd		
	to his room as he al	lows.			incontinent care.			
					The DNS/ designees will			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155038	B. W	NG		12/10/	2024
				CTD FET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
\4/4.TED	. = = = = = = = = = = = = = = = = = = =				EST WHITE RIVER BLVD		
WATERS	S EDGE VILLAGE			MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	During an observati	on on 12/9/24 at 11:45 a.m.,			round each shift to ensure		
	Resident C was sear	ted at a table in the dining area			residents receive timely ADL of	are.	
	being assisted by a	staff member to eat lunch. He			<u>-</u>		
		his seat with his face			how the corrective action	(s)	
	positioned down.				will be monitored to ensure the	` '	
	•				deficient practice will not recur		
	A document provid	ed by the Administrator, dated			i.e., what quality assurance	,	
	_	"[Resident C] Investigation			program will be put into place;		
		d the following: A surveillance			Ongoing compliance with		
	I	ed and CNA 8 was observed			this corrective action will be		
	l ⁻	unit to take CNA 2 home due			monitored through the facility		
		and CNA 2 talked for a few			Quality Assurance and		
		8 began to walk down the			Performance Improvement		
	hallway looking into resident rooms. When she				Program (QAPI). The		
	got to Resident C's room, she entered for				DNS/designee will be respons	ible	
	_	minute then reappeared. She			for completing the QAPI Audit		
		r resident room where CNA 4			timely. The ADL care tool will		
		to a resident. Then CNA 8 and			completed weekly for 4 weeks		
		ity. CNA 4 was observed			monthly for 6 months and	'	
		e minutes later exiting the room			quarterly thereafter for at least	2	
		ling care and entering			quarters. If threshold of 90% is		
	_	After just a few seconds, CNA			met, an action plan will be		
		he hallway using her cell			developed. Findings will be		
		observed entering the unit and			submitted to the QAPI Commit	tee	
		C's room. The two CNAs were			for review and follow up.		
		dent C down the hallway to			ion remain and remain apr		
	_	NA 4 reported to the					
		ad found Resident C in the					
		ith feces on his feet, pants,					
		conclusion statement indicated					
	· · · · · · · · · · · · · · · · · · ·	ound in his toilet area by CNA					
		por to the toilet to provide					
		[] was not in any distress from					
		rea alone as none of the 3					
	_	he was displaying any					
	_	ernal surveillance showed					
		walking with staff to the					
		C] was cared for within a					
		f time, approximately 6-7					
	_	CNA 8 should have stayed					
	Immuces. Howevel,	CITI O SHOULD HAVE SHAYED	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZTOD11 Facility ID: 000013

If continuation sheet Page 3 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE ((X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155038	B. WING		12/10/2024
	PROVIDER OR SUPPLIER	.	2200	ADDRESS, CITY, STATE, ZIP COD WEST WHITE RIVER BLVD CIE, IN 47303	•
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDEDS DI AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	with the resident un	til the staff responsible for his			
		he summary lacked specific			
	time stamps from th	ne surveillance video.			
	p.m., CNA 8 indica changed Resident C She didn't know wh He was seated on th his pants down. The front, his socks. It indicated there was the bathroom. She h CNA 4, who was w	interview on 12/9/24 at 6:22 ted she knew she should have before she left the facility. It is she had not cleaned him up. It is floor of his bathroom, with the ere was feces on his back, his was all over him. The CNA feces on the walls and floor of had reported his condition to torking on that unit, and then for her break and to take CNA			
	indicated Resident C CNA 4 was providing come across the hall was providing care had finished and lefter returned to the room reported Resident C indicated she had she when she complete which she thought went across the hall bathroom door was it, she observed Resident C with feces in his half socks. The walls, sit smeared with feces, began to curse at he she was going to ge indicated she left the she was or so. She	o on 12/9/24 at 2:14 p.m., CNA 4 C was part of her assignment. Ing care to another resident in a lway from Resident C. CNA 2 to the resident's roommate and the the room. CNA 2 and CNA 8 In she was working in and C was covered in feces. CNA 8 In thim in the bathroom. Indicating for the resident, Indicated to Resident C's room. The closed and when she opened sident C seated on the floor ir, face, entire clothing, and Ink, and floor were also I when Resident C saw her, he ier. She indicated to Resident C it help and would return. She is bathroom door open about the left the room and informed ded his assistance with			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZTOD11 Facility ID: 000013

If continuation sheet Page 4 of 13

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155038		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/10/2024		
	PROVIDER OR SUPPLIER		2200 W	ADDRESS, CITY, STATE, ZIP COD /EST WHITE RIVER BLVD E, 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
IAU	CNA 5 was assisting and arrived on the reminutes after she has was able to get Rest. CNA 4 indicated she clean up the bathroot CNA 2 and CNA 8 condition and had she leaving him alone. Soon as she could to felt it was possible aleaving the facility. During an interview indicated he was outduring smoke time. Coneeded assistance Resident Could be usually a two staff jindicated it was about completed the smol arrived in Resident was closed. The rest of the bathroom. Resthat his usual when calmed when he feld buring an interview Administrator indicated to come out resident would have open and close door command, but he has buring an interview Administrator indicated to come out resident would have open and close door command, but he has buring an interview Administrator indicated the memory care under the memory care under the command of the memory care under the command of the memory care under the command of the command of the memory care under the command of the command of the memory care under the command of th	g other residents to smoke, nemory care unit about 6-7 and spoken with him. CNA 5 and spoken with him to the substitution of the bathroom. She was surprised that would leave Resident C in that that the door to the bathroom. She called the administrator as to report the incident, as she abuse leaving him like that and and word on 12/9/24 at 1:58 p.m., CNA 5 and the transfer of the second aggressive and it was obtoo care for him. CNA 5 and 5-7 minutes before he are time supervision. When he C's room, the bathroom door ident was seated on the floor esident C was more agitated getting him to the shower, but	IAU			DAIE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZTOD11 Facility ID: 000013

If continuation sheet Page 5 of 13

i i		r í				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00		COMPLETED 12/10/2024	
		155038	B. WIN			12/10/	ZUZ4	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
WATERS	EDGE VILLAGE				E, IN 47303			
(X4) ID	SUMMARY	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	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	s going to take her home. It e at the end of their shift, they						
		taff before leaving the facility.						
	_	end of shift, but she was not						
	assigned to that unit	t to begin with and her						
	immediate assignment was to take CNA 2 home.							
	A current facility po	osition description, revised						
	10/2014, titled, "Certified Nursing Assistant Position Description," provided by the DON on 12/9/24 at 1:40 p.m., indicated the following: "Essential Position FunctionsProvides							
	delivery of care in a compassionate, quality manner with kindness, respect and dignity"							
		olicy, revised June 2023, titled,						
	"Abuse Prohibition,							
		vided by the Administrator on						
		.m., included the following:						
	-	Senior Communities has						
	_	and procedures which will						
		vith the knowledge and nsure each resident is treated						
	with individual resp							
	-	Failing to provide personal						
		embarrassment, depression,						
	poor self-esteem"	-						
	This Federal tag rela	ates to complaint IN00447929.						
	3.1-28(c)							
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(Reporting of Alleg							
		and record review, the facility	F 06	09	F609		01/03/2025	
	*	llegation of abuse to the			Neither signing nor submission	n of		
	•	t of Health for 1 of 2 residents			this plan of correction shall			
	reviewed for quality	y of care. (Resident C)			constitute an admission of any	/		
					deficiency or of any fact or			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZTOD11 Facility ID: 000013

If continuation sheet Page 6 of 13

01/22/2025 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 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 12/10/2024 155038 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2200 WEST WHITE RIVER BLVD WATERS EDGE VILLAGE 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 Finding includes: conclusion set forth in the "Statement of Deficiencies". During an interview on 12/9/24 at 2:14 p.m., CNA 4 This plan of correction is provided indicated she called the Administrator on 11/21/24 as evidence of the facility's desire following an incident with Resident C, who was to comply with the regulations and part of her assignment. She was providing care to to continue to provide quality care. another resident in a room across the hallway from Resident C. CNA 2 was providing care to the what corrective action(s) will resident's roommate and had finished and left the be accomplished for those room. CNA 2 and CNA 8 returned to the room she residents found to have been was working in and reported Resident C was affected by the deficient practice; covered in feces. CNA 8 indicated she had shut No residents were affected him in the bathroom. When CNA 4 completed by this incident. caring for the resident, which she thought was The Regional Director of around three minutes' time, she went across the Operations will inservice the hall to Resident C's room. The bathroom door was Executive Director on the closed and when she opened it, she observed Reportable Guidance Guidelines. Resident C seated on the floor with feces in his hair, face, entire clothing, and socks. The walls, how other residents having sink, and floor were also smeared with feces. the potential to be affected by the When Resident C saw her, he began to curse at same deficient practice will be her. She was surprised that CNA 2 and CNA 8 identified and what corrective would leave Resident C in that condition and had action(s) will be taken: shut the door to the bathroom leaving him alone. All residents have the She called the administrator as soon as she could potential to be affected, however to report the incident, as she felt it was possible no residents have been affected. abuse leaving him like that and leaving the facility. The Executive Director will receive re-education on the During an interview on 12/9/24 at 12:34 a.m., the reporting guidelines. Administrator indicated they had looked into the incident regarding Resident C. The corporate what measures will be put nurse consultant had also looked at the incident into place or what systemic and they felt it was not abuse or neglect. The changes will be made to ensure Administrator had reviewed the surveillance video that the deficient practice does not from that evening. recur;

FORM CMS-2567(02-99) Previous Versions Obsolete

During an interview on 12/10/24 at 10:16 a.m., the

Administrator indicated CNA 4 had called him the

evening of 11/21/24 and reported the situation

with Resident C and the two CNAs who had left

Event ID:

ZTOD11

Facility ID: 000013

If continuation sheet

The Regional Director of

Reportable Guidance Guidelines.

The DNS/Designee will

Operations will inservice the

Executive Director on the

Page 7 of 13

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155038	B. W	ING		12/10/	/2024
		<u> </u>	<u> </u>	CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹					
\\\\\ TEDC	S EDGE VIII ACE				EST WHITE RIVER BLVD		
WATERS	S EDGE VILLAGE			MONCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY		DATE
	1	ed CNA 4 if the two other			review the daily activity report	to	
	CNAs had informed	d her they were leaving the			ensure there are no allegation	s of	
		lied "yes." He indicated he			abuse which must be reported	l to	
		as not abuse, but poor care on			IDOH per guidelines.		
	_	ated to CNA 4 he would take			The Executive Director w	rill	
	care of it in the mor	rning.			review the reportable Guidano	e for	
					all incidents reported as poten	ıtial	
		report the alleged abuse to the			reportable issues.		
	Indiana Departmen	t of Health.	1		The Executive Director w	rill	
			1		communicate all potentially		
		olicy, revised June 2023, titled,			reportable issues to members		
	"Abuse Prohibition, Reporting, and				the home office team to includ	le	
	Investigation," provided by the Administrator on				the Regional Director of		
	12/10/24 at 10:16 a.m., indicated the following:				Operations.		
	"Reporting/Response:The Executive Director						
	will follow the reporting guidance delineated				how the corrective action		
		State Department of Health,			will be monitored to ensure the		
	I -	erm Care Incident Reporting			deficient practice will not recur	۲,	
	Policy"				i.e., what quality assurance		
					program will be put into place;		
		ana Department of Health			Ongoing compliance with	1	
		Term Care Abuse and Incident			this corrective action will be		
		effective date 12/8/23 through			monitored through the facility		
	12/8/24, and retriev				Quality Assurance and		
		/health/ltc/files/LTC-Abuse-Re			Performance Improvement		
	* • * •	ed the following: "B. Types			Program (QAPI). The		
	_	able Under Federal and State			DNS/designee will be respons		
	1	on of goods and services by			for completing the QAPI Audit		
	_	on of goods and services by			reportable weekly for 4 weeks	,	
		buse in which residents are			monthly for 6 months and	. 0	
		f goods or services that are			quarterly thereafter for at least		
	· ·	or maintain physical, mental,			quarters. If the threshold of 10		
	1 * *	rell-being. In these cases, staff			is not met, an action plan will be	be	
	I -	and ability to provide care and			developed. Findings will be	44	
		e not to do it, or acknowledge			submitted to the QAPI Commi	пее	
		stance from a resident(s),	1		for review and follow up		
		deficits to a resident(s)11.					
		the failure of the facility, its					
		ce providers to provide goods					
	and services to a re-	sident that are necessary to	1				I

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155038		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/10/2024	
	PROVIDER OR SUPPLIER		2200 \	FADDRESS, CITY, STATE, ZIP COD WEST WHITE RIVER BLVD CIE, IN 47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
PREFIX	REGULATORY OR avoid physical harm emotional distress Cross reference F55 This Federal tag rela 3.1-28(c) 483.12(c)(2)-(4) Investigate/Prever Based on interview failed to conduct a convestigation of alleresidents reviewed for the conduct of th	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION I, pain, mental anguish, or"	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION DATE 01/03/2025 of ded sire and care. will ce; ed
	4 can be observed in phone. CNA 5 was going into Resident	After just a few seconds, CNA in the hallway and used her cell observed entering the unit and C's room. The two CNA's Resident C down the hallway		how other residents havir the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;	_

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZTOD11 Facility ID: 000013

If continuation sheet

Page 9 of 13

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155038	B. W	ING		12/10/	2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	\				EST WHITE RIVER BLVD		
WATERS	S EDGE VILLAGE			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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	to the shower room.	. CNA 4 reported to the			All residents have the		
	Administrator she h	ad found Resident C in the			potential to be affected, however	/er	
	bathroom, soiled wi	th feces on his feet, pants,			no residents have been affect	ed.	
	shirt, and beard. A	conclusion statement indicated			The Executive Director w	rill	
	the following: "[Resident C] was found in his				receive re-education on the		
	toilet area by CNA 8. She closed the door to the				reporting guidelines and		
	toilet to provide dignity. [Resident C] was not in				Investigation Procedures. The		
	any distress from being in his toilet area alone as				Facility activity report was		
	none of the 3 CNAs reported that he was				reviewed for the past 15 days	to	
	displaying any distr	ress and the internal			ensure any allegations of negl	ect	
	surveillance showed	d [Resident C] calmly walking			were reported per policy.		
	with staff to the shower. [Resident C] was cared						
	for within a reasonable period of time,				what measures will be ρι	ıt	
	approximately 6-7 minutes. However, CNA 8				into place or what systemic		
	should have stayed with the resident until the				changes will be made to ensu	re	
	staff responsible for his care could arrive." The				that the deficient practice does	s not	
	summary lacked spe	ecific time stamps from the			recur;		
	surveillance video.						
					The Regional Director of		
	-	on 12/9/24 at 2:14 p.m., CNA 4			Operations will inservice the		
		the Administrator on 11/21/24			Executive Director on the		
		nt with Resident C, who was			Reportable Guidance Guidelin		
		ent. She was providing care to			and Reportable Investigations		
		a room across the hallway from			Executive Director will comple		
		was providing care to the			1.5 hour RELIAS learning cou	rse	
		e and had finished and left the			on conducting abuse		
		CNA 8 returned to the room she			investigations.		
	_	reported Resident C was			The Executive Director of		
		NA 8 indicated she had shut			Designee will communicate all		
		n. When CNA 4 completed			potentially reportable issues to		
	-	ent, which she thought was			members of the home office to		
		es' time, she went across the			within 1 hour of the incident to		
		room. The bathroom door was			include the Regional Director		
		e opened it, she observed			Operations, The Nurse consul	-	
		on the floor with feces in his			and the Director of Regulatory		
		othing, and socks. The walls,			Compliance to ensure the faci	-	
		e also smeared with feces.			remains compliant with Repor	table	
		aw her, he began to curse at			incidents.		
	-	sed that CNA 2 and CNA 8					
	would leave Reside	nt C in that condition and had			how the corrective action(s) w	ill be	

i î		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155038	B. W	ING		12/10/	/2024
				STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				EST WHITE RIVER BLVD		
\\/\\TEDS	S EDGE VILLAGE				E, IN 47303		
WATERS	S EDGE VILLAGE			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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	shut the door to the	bathroom leaving him alone.			monitored to ensure the defici	ent	
	She called the admi	nistrator as soon as she could			practice will not recur, i.e., who	at	
	to report the incider	nt, as she felt it was possible			quality assurance program wil	l be	
	abuse leaving him like that and leaving the facility.				put into place		
					Ongoing compliance with	1	
	During a telephone interview on 12/9/24 at 6:22				this corrective action will be	ļ	
	1 ^ .	ted she knew she should have			monitored through the facility	ļ	
		Resident C before she left the			Quality Assurance and	ļ	
	1	know why she had not cleaned			Performance Improvement		
	_	ted on the floor of his			Program (QAPI). The	ļ	
		pants down. There was feces			DNS/designee will be respons		
	on his back, his front, his socks. It was all over				for completing the QAPI Audit		
	him. She indicated there was feces on the walls				reportable/investigation weekl	-	
	and floor of the bathroom. She had reported his				4 weeks, monthly for 6 months		
	condition to the CNA 4, who was working on that				and quarterly thereafter for at		
		eft the facility for her break and			2 quarters. If threshold of 100		
	to take CNA 2 hom	e.			not met, an action plan will be		
		10/0/04			developed. Findings will be		
	_	on 12/9/24 at 12:34 a.m., the			submitted to the QAPI Commi	ttee	
		ated they had looked into the			for review and follow up.		
		Resident C. The corporate					
		d also looked at the incident					
	I	not abuse or neglect. The eviewed the surveillance video					
	_	The surveillance video was no					
	longer available and	d had been overwritten.				ļ	
	During an interview	on 12/10/24 at 10:16 a.m., the				ļ	
	_	ated CNA 4 had called him the				ļ	
		and reported the situation				ļ	
	_	d the two CNAs who had left					
		ed CNA 4 if the two CNAs had					
	I	vere leaving the facility, and				ļ	
	1	He indicated he told her that					
		but poor care on their part. He					
		he would take care of it in the					
		ted no employee statements or					
		nentation were available. He					
	_	ve put them in the shredder				ļ	
		ident was not considered					
	I son secuade the file	145110 1140 1101 00110140104	1		i e e e e e e e e e e e e e e e e e e e		Ī

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZTOD11 Facility ID: 000013

If continuation sheet Page 11 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPL	ETED
		155038	B. WING	G		12/10/	2024
			'	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			EST WHITE RIVER BLVD		
WATERS	S EDGE VILLAGE				E, IN 47303		
	T			-	,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		REFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
	abuse or neglect.						
	The facility had no	t reported the alleged abuse to					
	the Indiana Departs	-					
	life mulana Departi	ment of fleatin.					
	A current facility r	policy, revised June 2023, titled,					
	"Abuse Prohibition	-					
		vided by the Administrator on					
		a.m., included the following:					
		onse:The Executive Director					
		orting guidance delineated					
	through the Indiana	a State Department of Health,					
	Division of Long-7	Term Care Incident Reporting					
	Policy"						
		ana Department of Health					
		Term Care Abuse and Incident					
		effective date 12/8/23 through					
	12/8/24, and retriev						
		//health/ltc/files/LTC-Abuse-Re					
		ted the following: "B. Types					
	_	table Under Federal and State					
		ion of goods and services by					
	_	ion of goods and services by					
		ouse in which residents are					
		f goods or services that are					
		or maintain physical, mental,					
		vell-being. In these cases, staff					
	_	and ability to provide care and e not to do it, or acknowledge					
		stance from a resident(s),					
		e deficits to a resident(s)11.					
		s the failure of the facility, its					
	"	ce providers to provide goods					
		esident that are necessary to					
		m, pain, mental anguish, or					
	emotional distress.	-					
	Cross reference F5	50 and F609.					
I	I		1				l

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZTOD11 Facility ID: 000013

If continuation sheet Page 12 of 13

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

PRINTED: 01/22/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155038	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/10/2024	
	PROVIDER OR SUPPLIER			2200 W	ADDRESS, CITY, STATE, ZIP COD EST WHITE RIVER BLVD E, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
	This Federal tag related 3.1-28(d)	ates to complaint IN00447929.					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZTOD11 Facility ID: 000013 If continuation sheet Page 13 of 13