STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155038	A. BUILDING 00 B. WING	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS EDGE VILLAGE	2200 WEST WHITE RIVER BLVD MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00447929. Complaint IN00447929 - Federal/state deficiencies related to the allegations are cited at F550, F609 and F610. Survey dates: December 9 & 10, 2024 Facility number: 000013 Provider number: 155038 AIM number: 100266100 Census Bed Type: SNF/NF: 62 Total: 62 Census Payor Type: Medicaid: 60 Other: 2 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 23, 2024.	F 0000	I wish to request a Desk Review/Paper Compliance	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on record review and interview, the facility failed to protect a resident's dignity and failed to assist him with ADL care, leaving him in a soiled bathroom for another staff member to assist following an incontinence episode for 1 of 2 residents reviewed for quality of care. (Resident C) Using the reasonable person concept, it would	F 0550	**F550** Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies".	01/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Thomas	Executive Director	01/03/2025

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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	be likely that a dependent, vulnerable person unable to care for themselves could experience recurrent fear or anxiety when the facility staff failed to assist them during a vulnerable episode of incontinence where he was found to be unsupervised, and covered in feces, seated on a bathroom floor with staff closing the door. Findings include: A complaint filed with the Indiana Department of Health indicated Resident C had been in a bathroom, alone, with his door shut and was unable to open doors due to his diagnoses. Resident C's clinical record was reviewed on 10/9/24 at 11:15 a.m. Diagnoses included dementia, depression, psychotic disorder with delusions, anxiety disorder, dystonia, and history of alcohol abuse. A quarterly Minimum Data Set (MDS) assessment, dated 11/19/24, indicated the resident had severe cognitive impairment, required substantial/maximal assistance with eating and was dependent on staff for toileting, oral hygiene, bathing, dressing, mobility, and transfers. The resident was able to ambulate with supervision and touching assistance. A current care plan, dated 9/11/23, indicated Resident C required assistance with toileting due to incontinence of bowel and bladder, impaired mobility, and potential to play in his own feces at times. Interventions included, (10/8/24) resident's legal representative wished for his dignity to be maintained as much as possible during times of incontinence and to allow privacy by guiding him to his room as he allows.		This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C has been observed since the incident and has had no episodes of fear or anxiety related to the incident on 11/21/24. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents on the Dementia care unit have the potential to be affected. However no other residents were found to be affected. A Nursing staff inservice was conducted on resident rights with an emphasis on dignity and incontinent care. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All nursing staff inservice was conducted on resident rights with an emphasis on dignity and incontinent care. The DNS/ designees will	

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	During an observation on 12/9/24 at 11:45 a.m., Resident C was seated at a table in the dining area being assisted by a staff member to eat lunch. He was bent forward in his seat with his face positioned down. A document provided by the Administrator, dated 11/22/24 and titled, "[Resident C] Investigation summary," indicated the following: A surveillance system was reviewed and CNA 8 was observed on the memory care unit to take CNA 2 home due to sickness. CNA 8 and CNA 2 talked for a few seconds, then CNA 8 began to walk down the hallway looking into resident rooms. When she got to Resident C's room, she entered for approximately one minute then reappeared. She then entered another resident room where CNA 4 was providing care to a resident. Then CNA 8 and CNA 2 left the facility. CNA 4 was observed approximately three minutes later exiting the room she had been providing care and entering Resident C's room. After just a few seconds, CNA 4 was observed in the hallway using her cell phone. CNA 5 was observed entering the unit and going into Resident C's room. The two CNAs were seen escorting Resident C down the hallway to the shower room. CNA 4 reported to the Administrator she had found Resident C in the bathroom, soiled with feces on his feet, pants, shirt, and beard. A conclusion statement indicated [Resident C] was found in his toilet area by CNA 8. She closed the door to the toilet to provide dignity. [Resident C] was not in any distress from being in his toilet area alone as none of the 3 CNAs reported that he was displaying any distress and the internal surveillance showed [Resident C] calmly walking with staff to the shower. [Resident C] was cared for within a reasonable period of time, approximately 6-7 minutes. However, CNA 8 should have stayed		round each shift to ensure residents receive timely ADL care. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool timely. The ADL care tool will be completed weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	with the resident until the staff responsible for his care could arrive. The summary lacked specific time stamps from the surveillance video. During a telephone interview on 12/9/24 at 6:22 p.m., CNA 8 indicated she knew she should have changed Resident C before she left the facility. She didn't know why she had not cleaned him up. He was seated on the floor of his bathroom, with his pants down. There was feces on his back, his front, his socks. It was all over him. The CNA indicated there was feces on the walls and floor of the bathroom. She had reported his condition to CNA 4, who was working on that unit, and then she left the facility for her break and to take CNA 2 home. During an interview on 12/9/24 at 2:14 p.m., CNA 4 indicated Resident C was part of her assignment. CNA 4 was providing care to another resident in a room across the hallway from Resident C. CNA 2 was providing care to the resident's roommate and had finished and left the room. CNA 2 and CNA 8 returned to the room she was working in and reported Resident C was covered in feces. CNA 8 indicated she had shut him in the bathroom. When she completed caring for the resident, which she thought was around three minutes, she went across the hall to Resident C's room. The bathroom door was closed and when she opened it, she observed Resident C seated on the floor with feces in his hair, face, entire clothing, and socks. The walls, sink, and floor were also smeared with feces. When Resident C saw her, he began to curse at her. She indicated to Resident C she was going to get help and would return. She indicated she left the bathroom door open about 12 inches or so. She left the room and informed CNA 5 that she needed his assistance with Resident C as soon as possible. She indicated			

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	CNA 5 was assisting other residents to smoke, and arrived on the memory care unit about 6-7 minutes after she had spoken with him. CNA 5 was able to get Resident C to the shower room. CNA 4 indicated she remained in the room to clean up the bathroom. She was surprised that CNA 2 and CNA 8 would leave Resident C in that condition and had shut the door to the bathroom leaving him alone. She called the administrator as soon as she could to report the incident, as she felt it was possible abuse leaving him like that and leaving the facility. During an interview on 12/9/24 at 1:58 p.m., CNA 5 indicated he was outside with other residents during smoke time. CNA 4 had indicated Resident C needed assistance and was covered in feces. Resident C could become aggressive and it was usually a two staff job to care for him. CNA 5 indicated it was about 5-7 minutes before he completed the smoke time supervision. When he arrived in Resident C's room, the bathroom door was closed. The resident was seated on the floor of the bathroom. Resident C was more agitated that his usual when getting him to the shower, but calmed when he felt the water. During an interview on 12/9/24 at 12:34 p.m., the Administrator indicated the reason CNA 8 had shut the door to the bathroom was so he would not come out into the hallway. If the resident had wanted to come out, the Administrator felt the resident would have done so because he could open and close doors. He may not do this on command, but he had seen him open doors before. During an interview on 12/10/24 at 10:16 a.m., the Administrator indicated CNA 2 was scheduled on the memory care unit on 11/21/24 from 2:00 p.m. to 10:00 p.m. and became ill. CNA 8 was preparing to			

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	go on break and was going to take her home. It was like anyone else at the end of their shift, they reported off to the staff before leaving the facility. It was not CNA 8's end of shift, but she was not assigned to that unit to begin with and her immediate assignment was to take CNA 2 home. A current facility position 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 Functions...Provides delivery of care in a compassionate, quality manner with kindness, respect and dignity...." A current facility policy, revised June 2023, titled, "Abuse Prohibition, Reporting, and Investigation," provided by the Administrator on 12/10/24 at 10:16 a.m., included the following: "Policy:...American Senior Communities has established policies and procedures which will provide personnel with the knowledge and training to further ensure each resident is treated with individual respect and dignity....Neglect....Failing to provide personal hygiene resulting in embarrassment, depression, poor self-esteem..." This Federal tag relates to complaint IN00447929. 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 interview and record review, the facility failed to report an allegation of abuse to the Indiana Department of Health for 1 of 2 residents reviewed for quality of care. (Resident C)	F 0609	**F609** Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or	01/03/2025

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

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	the facility. He asked CNA 4 if the two other CNAs had informed her they were leaving the facility, and she replied "yes." He indicated he told her that this was not abuse, but poor care on their part. He indicated to CNA 4 he would take care of it in the morning. The facility did not report the alleged abuse to the Indiana Department of Health. A current facility policy, revised June 2023, titled, "Abuse Prohibition, Reporting, and Investigation," provided by the Administrator on 12/10/24 at 10:16 a.m., indicated the following: "...Reporting/Response: ...The Executive Director will follow the reporting guidance delineated through the Indiana State Department of Health, Division of Long-Term Care Incident Reporting Policy...." Review of the Indiana Department of Health policy titled "Long Term Care Abuse and Incident Reporting Policy," effective date 12/8/23 through 12/8/24, and retrieved from https://www.in.gov/health/ltc/files/LTC-Abuse-Reporting.pdf, indicated the following: "...B. Types of Incidents Reportable Under Federal and State Rules...3. Deprivation of goods and services by staff: The deprivation of goods and services by staff is a form of abuse in which residents are deprived by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. In these cases, staff has the knowledge and ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident(s).....11. Neglect: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to		review the daily activity report to ensure there are no allegations of abuse which must be reported to IDOH per guidelines. The Executive Director will review the reportable Guidance for all incidents reported as potential reportable issues. The Executive Director will communicate all potentially reportable issues to members of the home office team to include the Regional Director of Operations. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool reportable weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	

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	avoid physical harm, pain, mental anguish, or emotional distress...." Cross reference F550. This Federal tag relates to complaint IN00447929. 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation Based on interview and record review, the facility failed to conduct a complete and thorough investigation of alleged neglect for 1 of 2 residents reviewed for quality of care. (Resident C) Findings include: A document provided by the Administrator, dated 11/22/24, titled, "[Resident C] Investigation summary," indicated the following: A surveillance system was reviewed and CNA 8 was observed on the memory care unit to take CNA 2 home due to sickness. CNA 8 and CNA 2 talked for a few seconds, then CNA 8 began to walk down the hallway looking into resident rooms. When she got to Resident C's room, she entered for approximately one minute then reappeared. She then entered another resident room where CNA 4 was providing care to a resident. Then CNA 8 and CNA 2 left the facility. CNA 4 was observed approximately three minutes later exiting the room she had been providing care and entering Resident C's room. After just a few seconds, CNA 4 can be observed in the hallway and used her cell phone. CNA 5 was observed entering the unit and going into Resident C's room. The two CNA's were seen escorting Resident C down the hallway	F 0610	**F610** Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this incident. The Executive Director will receive re-education on the Reporting Guidelines and Investigation Procedures. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	01/03/2025

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	to the shower room. CNA 4 reported to the Administrator she had found Resident C in the bathroom, soiled with feces on his feet, pants, shirt, and beard. A conclusion statement indicated the following: "[Resident C] was found in his toilet area by CNA 8. She closed the door to the toilet to provide dignity. [Resident C] was not in any distress from being in his toilet area alone as none of the 3 CNAs reported that he was displaying any distress and the internal surveillance showed [Resident C] calmly walking with staff to the shower. [Resident C] was cared for within a reasonable period of time, approximately 6-7 minutes. However, CNA 8 should have stayed with the resident until the staff responsible for his care could arrive." The summary lacked specific time stamps from the surveillance video. During an interview on 12/9/24 at 2:14 p.m., CNA 4 indicated she called the Administrator on 11/21/24 following an incident with Resident C, who was part of her assignment. She was providing care to another resident in a room across the hallway from Resident C. CNA 2 was providing care to the resident's roommate and had finished and left the room. CNA 2 and CNA 8 returned to the room she was working in and reported Resident C was covered in feces. CNA 8 indicated she had shut him in the bathroom. When CNA 4 completed caring for the resident, which she thought was around three minutes' time, she went across the hall to Resident C's room. The bathroom door was closed and when she opened it, she observed Resident C seated on the floor with feces in his hair, face, entire clothing, and socks. The walls, sink, and floor were also smeared with feces. When Resident C saw her, he began to curse at her. She was surprised that CNA 2 and CNA 8 would leave Resident C in that condition and had		All residents have the potential to be affected, however no residents have been affected. The Executive Director will receive re-education on the reporting guidelines and Investigation Procedures. The Facility activity report was reviewed for the past 15 days to ensure any allegations of neglect were reported per policy. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Regional Director of Operations will inservice the Executive Director on the Reportable Guidance Guidelines and Reportable Investigations. The Executive Director will complete a 1.5 hour RELIAS learning course on conducting abuse investigations. The Executive Director or Designee will communicate all potentially reportable issues to members of the home office team within 1 hour of the incident to include the Regional Director of Operations, The Nurse consultant, and the Director of Regulatory Compliance to ensure the facility remains compliant with Reportable incidents. how the corrective action(s) will be	

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	shut the door to the bathroom leaving him alone. She called the administrator as soon as she could to report the incident, as she felt it was possible abuse leaving him like that and leaving the facility. During a telephone interview on 12/9/24 at 6:22 p.m., CNA 8 indicated she knew she should have changed (cleaned) Resident C before she left the facility. She didn't know why she had not cleaned him up. He was seated on the floor of his bathroom, with his pants down. There was feces on his back, his front, his socks. It was all over him. She indicated there was feces on the walls and floor of the bathroom. She had reported his condition to the CNA 4, who was working on that unit, and then she left the facility for her break and to take CNA 2 home. During an interview on 12/9/24 at 12:34 a.m., the Administrator indicated they had looked into the incident regarding Resident C. The corporate nurse consultant had also looked at the incident and they felt it was not abuse or neglect. The Administrator had reviewed the surveillance video from that evening. The surveillance video was no longer available and had been overwritten. 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 the facility. He asked CNA 4 if the two CNAs had informed her they were leaving the facility, and she replied "yes." He indicated he told her that this was not abuse, but poor care on their part. He indicated to CNA 4 he would take care of it in the morning. He indicated no employee statements or investigation documentation were available. He believed he may have put them in the shredder box because the incident was not considered		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool reportable/investigation weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 100 % is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155038	A. BUILDING 00 B. WING	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS EDGE VILLAGE	2200 WEST WHITE RIVER BLVD MUNCIE, IN 47303

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	abuse or neglect. The facility had not reported the alleged abuse to the Indiana Department of Health. A current facility policy, revised June 2023, titled, "Abuse Prohibition, Reporting, and Investigation," provided by the Administrator on 12/10/24 at 10:16 a.m., included the following: "...Reporting/Response: ...The Executive Director will follow the reporting guidance delineated through the Indiana State Department of Health, Division of Long-Term Care Incident Reporting Policy...." Review of the Indiana Department of Health policy titled "Long Term Care Abuse and Incident Reporting Policy," effective date 12/8/23 through 12/8/24, and retrieved from https://www.in.gov/health/ltc/files/LTC-Abuse-Reporting.pdf, indicated the following: "...B. Types of Incidents Reportable Under Federal and State Rules...3. Deprivation of goods and services by staff: The deprivation of goods and services by staff is a form of abuse in which residents are deprived by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. In these cases, staff has the knowledge and ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident(s).....11. Neglect: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress...." Cross reference F550 and F609.			

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	This Federal tag relates to complaint IN00447929. 3.1-28(d)			