STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155006	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Wabash Skilled Nursing Facility East The	1900 N Alber St Wabash, IN 46992

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to ensure an allegation of staff to resident physical and verbal abuse was reported to the State Agency (Indiana Department of Health) for 1 of 3 residents reviewed for abuse. (Resident E)Findings include:Resident E's clinical record was reviewed on 12/10/25 at 9:50 a.m. Diagnoses included dementia and major depressive disorder.Current physician's orders included behavior monitoring every shift for restlessness, nervousness, mood disturbances (8/7/25), memantine 10 mg give one tablet by mouth every morning and at bedtime for dementia (11/2/23), and sertraline 100 mg give one table in the morning for depression (3/7/25).A quarterly Minimum Data Set (MDS) assessment, dated 9/17/25, indicated Resident E was severely cognitively impaired, did not experience hallucinations or delusions, and displayed no physical or verbal symptoms towards others during the assessment period.A care plan, initiated 11/17/25, indicated Resident E displayed behavioral symptoms related to dementia which included restlessness, nervousness, and mood disturbances. Interventions included administering psycho-active medications as ordered, recording behavioral symptoms of verbal/physical aggression and inappropriate behaviors, intervene when any inappropriate behavior was observed, and use creative refocusing to alter behavioral patterns.During an interview with the Dietary Manager (DM), on 12/8/25 at 12:59 p.m., she indicated, on 11/3/25, she observed CNA 2 become aggressive with Resident E during lunch. Resident E was sitting at her dining table when CNA 2 placed a drink for another resident on the table. When Resident E and CNA 2 reached for the drink at the same time, Resident E scratched the CNA's hand. CNA 2 grabbed both Resident E's wrists and in a very loud voice said, Don't scratch me!. The DM indicated she went to the DON's office to report the incident. She was later told, by the Administrator, there were no findings regarding the incident. The DM asked the Administrator if he needed her written statement and he said he did not need one.During an interview with the Administrator on 12/8/25 at 1:24 p.m., he indicated there had been no report(s) of abuse from staff in the past 60 days and no grievances were filed during that time.During an interview with the Administrator on 12/8/25 at 3:16 p.m., he indicated he was ill the week of the alleged incident. Resident E required cues or reminders to eat. CNA 3 first brought the incident to his attention on an unknown date. CNA 3 heard the DM talking about something happening during lunch service. He did an investigation but had no findings. The Administrator indicated the DM was not a reliable witness. Approximately two weeks before the 11/3/25 incident, during an interdisciplinary team meeting (IDT), the DM had told him she wanted CNA 2 fired or she would walk that day. The DM and CNA 2 had a history outside of working at the facility. The Administrator did not think the 11/3/25 incident was reportable. He talked to CNA 2, who told him she said We don't scratch like that, honey when Resident E tried to scratch her. He had no complaints from residents regarding CNA 2. He did have complaints from other staff members regarding CNA 2. He had not heard about hands being put on Resident E until the next IDT meeting. The DM had tried to do her own investigation and reported the incident to the DON while he was out sick. He later went to the DM and told her that at no point should she ever be doing her own investigation. If she truly thought she witnessed abuse, she would have called the police. The Administrator indicated he should have reported the allegation of abuse to IDOH.During an interview with CNA 3 on 12/8/25 at 3:33 p.m., she indicated she did not see anything between Resident E and CNA 2, but was standing at the service window to the kitchen when she heard the DM telling another staff member about the alleged incident. The DM said she was sick and tired of CNA 2 treating the residents poorly and putting their hands on them. CNA 3 had never seen CNA 2 put her hands on residents or speak rudely to them. CNA 3 did not know the reason but knew the DM and CNA 2 did not like each other.During an interview with the DON on 12/8/25 at 4:05 p.m., she indicated she was in the Social Services Director's (SSD) office when the DM entered and said she had tried to check the cameras because she saw CNA 2 grab Resident E by the face. The DM wanted to report the incident to the Administrator. The DON contacted the Administrator at home. After the DM left the office, CNA 3 reported the DM was slamming things in the kitchen, saying CNA 2 grabbed Resident E by the face. CNA 3 did not see or hear anything during the lunch service. CNA 2 was interviewed and was completely confused about the allegation of abuse. CNA 2 described the incident where Resident E tried to take a drink and tried to scratch the CNA. CNA 2 pulled away and said No, we don't scratch. The DON said there was no way the DM could have seen anything happen from her vantage point in the kitchen. Nobody complained about CNA 2 being rude or rough with residents. After speaking with CNA 2, nobody else saw anything and the DON let the Administrator know of her findings. Resident E could be very aggressive and there were times when CNA

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to investigate an allegation of staff to resident abuse and failed to implement the facility policy to protect residents following an allegation of abuse for 1 of 3 residents reviewed for abuse. (Resident E)Findings include:An anonymous allegation of staff to resident verbal abuse involving Resident E was received by the Indiana Department of Health on 11/14/25. During an interview with the Dietary Manager (DM), on 12/8/25 at 12:59 p.m., she indicated, on 11/3/25, she observed CNA 2 become aggressive with Resident E during lunch. Resident E was sitting at her dining table when CNA 2 placed a drink for another resident on the table. When Resident E and CNA 2 reached for the drink at the same time, Resident E scratched the CNA's hand. CNA 2 grabbed both Resident E's wrists and in a very loud voice said, Don't scratch me!. The DM indicated she went to the DON's office to report the incident. She was later told, by the Administrator, there were no findings regarding the incident. The DM asked the Administrator if he needed her written statement and he said he did not need one.During an interview with the Administrator on 12/8/25 at 1:24 p.m., he indicated there had been no report(s) of abuse from staff in the past 60 days and no grievances were filed during that time.During an interview with the Administrator on 12/8/25 at 3:16 p.m., he indicated he was ill the week of the alleged incident. Resident E required cues or reminders to eat. CNA 3 first brought the incident to his attention on an unknown date. CNA 3 heard the DM talking about something happening during lunch service. He did an investigation but had no findings. The Administrator indicated the DM was not a reliable witness. Approximately two weeks before the 11/3/25 incident, during an interdisciplinary team meeting (IDT), the DM had told him she wanted CNA 2 fired or she would walk that day. The DM and CNA 2 had a history outside of working at the facility. The Administrator did not think the 11/3/25 incident was reportable. He talked to CNA 2, who told him she said We don't scratch like that, honey when Resident E tried to scratch her. He had no complaints from residents regarding CNA 2. He did have complaints from other staff members regarding CNA 2. He had not heard about hands being put on Resident E until the next IDT meeting. The DM had tried to do her own investigation and reported the incident to the DON while he was out sick. He later went to the DM and told her that at no point should she ever be doing her own investigation. If she truly thought she witnessed abuse, she would have called the police. The Administrator indicated he should have reported the allegation of abuse to IDOH. During an interview with the DON on 12/8/25 at 4:05 p.m., she indicated she was in the Social Services Director's (SSD) office when the DM entered and said she had tried to check the cameras because she saw CNA 2 grab Resident E by the face. The DM wanted to report the incident to the Administrator. The DON contacted the Administrator at home. After the DM left the office, CNA 3 reported the DM was slamming things in the kitchen, saying CNA 2 grabbed Resident E by the face. CNA 3 did not see or hear anything during the lunch service. CNA 2 was interviewed and was completely confused about the allegation of abuse. CNA 2 described the incident where Resident E tried to take a drink and tried to scratch the CNA. CNA 2 pulled away and said No, we don't scratch. The DON said there was no way the DM could have seen anything happen from her vantage point in the kitchen. Nobody complained about CNA 2 being rude or rough with residents. After speaking with CNA 2, nobody else saw anything and the DON let the Administrator know of her findings. Resident E could be very aggressive and there were times when CNA 2 could have been on the receiving end of Resident E fighting or resisting care. The Administrator was responsible for reporting alleged incidents of abuse to the state. That was why she called him right after the DM made the allegation of abuse. If the Administrator was unavailable to report an incident of abuse, the DON would contact a corporate consultant. She could not recall if she had collected written statements from the DM, CNA 2, or CNA 3.Resident E's clinical record was reviewed on 12/10/25 at 9:50 a.m. Diagnoses included dementia and major depressive disorder.Current physician's orders included behavior monitoring every shift for restlessness, nervousness, mood disturbances (8/7/25), memantine 10 mg give one tablet by mouth every morning and at bedtime for dementia (11/2/23), and sertraline 100 mg give one table in the morning for depression (3/7/25).A quarterly Minimum Data Set (MDS) assessment, dated 9/17/25, indicated Resident E was severely cognitively impaired, did not experience hallucinations or delusions, and displayed no physical or verbal symptoms towards others during the assessment period.A care plan, initiated 11/17/25, indicated Resident E displayed behavioral symptoms related to dementia which included restlessness, nervousness, and mood disturbances. 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