STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/16/2026
NAME OF PROVIDER OR SUPPLIER: Waters of Wabash Skilled Nursing Facility East The		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect a resident's right to be free from staff abuse during care for 1 of 3 residents reviewed for abuse. (Resident C)Findings include:Resident C's clinical record was reviewed on 2/13/26 at 12:50 p.m. Diagnoses included dementia and osteoporosis without fracture.A quarterly, 12/17/25, Minimum Data Set (MDS) assessment indicated Resident C's cognition could not be assessed. Resident C was dependent on staff members for toileting hygiene, maximum assistance for upper and lower body dressing, moderate assistance for changing from lying to a sitting position and maximum assistance.Resident C's current care plans included the following: I have a self-care deficit and require assistance with ADLs (activities of daily living) to maintain the highest possible level of functioning as evidenced by the following limitations and potential contributing factors: weakness, unsteady gait, and dementia. Interventions included: provide assistance with all ADLs as required per my dependence on needs: eating, transferring, bed mobility, dressing, personal hygiene, ambulation and personal hygiene, redirect me as needed.During an interview, on 2/16/26 at 9:47 a.m., CNA 4 indicated CNA 3 walked up to Resident C and started pulling on the resident's arm in a forceful way. Then, CNA 3 stated to Resident C we can do this the easy way or the hard way. While Resident C was clamping her legs shut, CNA 3 told Resident C to open your da** legs. Resident C didn't start becoming combative until CNA 3 started roughly yanking on Resident C's arm.During an interview, on 2/16/26 at 9:57 am., CNA 3 indicated she was training CNA 4 and there were claims that she (CNA 3) stated, we can do this the easy way or the hard way, but she meant it as we can do this in bed or in the bathroom. She was not going to force Resident C to open her legs. She would just shimmy the brief up her legs. CNA 3 denied pulling on residents' arm forcefully. She grabbed underneath Resident C's arm, as she was pulling Resident C up in bed, Resident C leaned backwards, which could make it look like she was pulling on Resident C's arm. CNA 3 did not recall using a curse word, and only remembered telling Resident C to open her legs, but would never force Resident C to do anything the resident didn't want to do.During an interview, on 2/16/26 at 11:13 a.m., RN 5 indicated CNA 4 came to her after providing care to Resident C. CNA 4 indicated CNA 3 had cursed and raised her voice toward Resident C, which made CNA 4 uncomfortable while providing care. RN 5 called the DON and Administrator to inform them of the incident. While CNA 4 was on the phone with them, RN 5 went to assess Resident C and to make sure CNA 3 was not providing any care to other residents. RN 5 walked CNA 3 out of the facility and the facility started their investigation into the allegations. A facility self-reported incident, submitted to the Indiana Department of Health on 2/9/26 at 10:01 p.m., indicated CNA 3 was being rude to Resident C during care while also stating you need to open your da** legs.During an interview, on 2/13/26 at 12:14 p.m., the Administrator indicated CNA 3 and 4 were providing care to Resident C. Resident C became combative during care. CNA 3 stated they could do this the easy way or the hard way, while also holding Resident C's arm down while providing care. CNA 4 didn't feel right about the situation. RN 5 (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called and informed the Administrator of the allegation, and he told RN 5 to send CNA 3 home. Review of staff statements provided by the facility, on 2/13/26 at 12:30 p.m., indicated the following:A written statement indicated that the Administrator spoke with CNA 3 regarding the incident. CNA 3 admitted she used inappropriate language with Resident C, stating we can do this the easy way or the hard way. CNA 3 stated she said that to herself under her breath. CNA 3 stated it was not meant to be heard, and she would never harm a resident. The hard way was having to shimmy the resident's brief up her legs rather than the resident's legs being open. Regardless, the language resulted in her employment being terminated.A written statement indicated that the Administrator spoke with CNA 4 regarding the incident. CNA 4 indicated CNA 3 used rude language and had been rough while providing care to Resident C. Resident C was combative during care causing CNA 3 to firmly grasp Resident C's arm to prevent further hitting or slapping from the resident. While performing care, CNA 3 stated we can do this the easy way or the hard way in a quiet tone.Review of an Employee Disciplinary Action report, on 2/13/26, indicated CNA 3 had violated work performance, customer service, safety violation, code of conduct, compliance violation and failure to follow instructions. The report indicated, on 2/3/25, CNA 3 was sent home due to an altercation with a resident who had dementia. On another occasion, CNA 3 stated in front of a resident that their bowel movement smelled and it was going to make her sick.A current facility policy, dated 7/15/21, revised on 5/15/23, titled Abuse Reporting Policy, provided by the Administrator, on 2/16/26 at 11:22 a.m., indicated the following: .Policy: This facility will not tolerate resident abuse or treatment by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies, family members, legal guardians, friends or other individuals. Verbal abuse: any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability This citation relates to Intake 2739361.3.1-27(b)