STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155038	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Village	2200 West White River Blvd Muncie, IN 47303

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 observation, interview, and record review, the facility failed to ensure residents were free from staff to resident verbal abuse for 3 of 4 residents reviewed abuse (Resident B, F and G).Findings include:During an interview on 11/24/25 at 9:27 a.m., Resident B indicated he and LPN 1 had previously had a verbal argument. They both got upset and cursed. He was fine. He wasn't scared then, or currently. People swear when they are angry.During an interview on 11/24/25 at 1:46 p.m., LPN 2 indicated on the evening of 9/30/25, she was working with LPN 1 when Resident B came to the medication cart and asked her to contact his hospice company for an increase in his anxiety medication because he felt his current dosage wasn't effective. She looked and saw LPN 1 was at the nurses station. She indicated perhaps LPN 1 could call because he was at the station with the phone. Resident B replied NO, that m----r f----r won't help me. In reply, LPN 1 loudly called Resident B a m----r f----r. She immediately told LPN 1 he could not talk to a resident that way. Resident B and LPN1 continued to curse at each other saying F----r. LPN 2 then said to stop, loudly. Both quieted. She asked Resident B to please go to his room. The resident went to his room. Because the exchange was loud, two other residents who were in the hallway heard the exchange as well, Residents F and G. While Resident B went to his room, she called the DON to report the verbal abuse and cursing. LPN 1 remained seated at the desk and did not interact with residents. He stayed at the desk until a member of management arrived, spoke with him and sent him home. During the same interview, LPN 2 indicated she had filled one other concern related to LPN 1. The concern was months earlier, she believed in the summertime. Resident E was crying out, yelling, and banging on things. She had asked LPN 1 if the resident should have a pain pill now. LPN1 stated that because of his behavior, the resident was going to wait for his pill until there very last minute. She requested him give the pill more than once and was told he would have to wait. She reported her concern to Management Nurse 3 and was asked to give a written statement, which she provided. She was not informed of the outcome, but believed Management Nurse 3 did investigate her concern.During an interview on11/24/25 at 11:00 a.m., QMA 4 indicated she had not worked on 9/30/25 and had not witnessed an exchange between LPN1 and Resident B. However, she had previously filled a concern on behalf of Resident H, who had alleged LPN 1 had come into his room and given him a urine sample collection cup and told the resident he had to catch the bedbug and put it in the cup or no one was coming in his room to provide care. At the time the resident made the statement, she observed an urine sample cup in the room. The resident was upset. He indicated he did not have bedbugs and LPN 1 had made him feel dirty. QMA 4 told the resident staff were not allowed to withhold care. She then provided care and found chocolate cake crumbs that she believed other staff members had thought were bedbugs. After discussing it with the resident, she completed a concern form that alleged LPN1 threatened to withhold care due to bedbugs and made 3 copies placing them under the office doors of the Administrator, DON and ADON. She was never interviewed regarding the concern. She referenced this previous concern on her 10/2/25 written statement regarding the 9/30/25 event. Resident B's clinical record was reviewed on 11/21/25 at 1:07 p.m. Current diagnoses include chronic obstructive pulmonary disease, bipolar disorder, depression and anxiety. An 11/13/25, significant change, MDS (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Minimum Data Set) Assessment indicated the resident was cognitively intact and had not displayed maladaptive behaviors during the assessment period. The resident had a 7/25/25, care plan problem/need regarding a past history of trauma and PTSD (post traumatic stress disorder) with a history of self- harming, a history of suicidal and homicidal ideations, a history of fighting and using profanity when angry/frustrated. He was at risk for retriggering trauma. An approach to this problem was to encourage the resident to express anger and frustration in an appropriate manner.A 10/01/2025, 1:40 p.m., Progress Note indicated, Resident did not have much to say about last night's incident with a nurse. Resident states he feels safe in the building, no staff have been mean to him, and he hasn't heard staff be mean to anyone else . A 10/01/2025, 12:00 p.m., Progress Note indicated, Resident reports that ?last night me and a nurse had a few words' and it led to ?arguing between us'. Resident reports that he feels safe in the facility and was not fearful during the verbal exchange. Stated ?ain't nothin that scares me but a little gray mouse', with smile. Resident denies any physical interaction between he and the staff member. A 9/30/25, facility self-reported incident filed with the Indiana Department of Health indicated the facility received and allegation of verbal abuse that LPN 1 had cursed at Resident B during a verbal argument on 9/30/25. LPN1 was suspended pending investigation. Resident B and all other residents who overheard the exchange would be monitored for signs and symptoms of distress.An undated, handwritten statement signed by LPN2, which was contained in the facility investigation file related to the 9/30/25 reported event, indicated Resident B had asked for an increase in his antianxiety medication. She asked could LPN 1 make the call because he was seated at the station. Resident B said f--- him, he ain't gonna do sh--. LPN 1 then screamed F--- you. The two went back and forth screaming F---you several times. LPN1 also called the resident a F---ing idiot. She stepped between them and told LPN1 to knock it off. You can't talk to residents like this. They said a few more words. She said stop loudly and it finally ended. She asked the resident to please go to his room. She then called the DON and reported the event.An undated, handwritten statement signed by Resident B, which was contained in the facility investigation file related to the 9/30/25 reported event, indicated Resident B and LPN 1 had argued and one thing led to another some cuss words were said F word was said a lot between the two of us.A 9/30/25, handwritten statement signed by LPN 1, which was contained in the facility investigation file related to the 9/30/25 reported event, Resident B had yelled at him and he yelled back. The statement did not indicate profanity was used by either party.A 9/30/25, handwritten statement signed by Resident F, which was contained in the facility investigation file related to the 9/30/25 reported event, indicated Resident D was seated in the hallway and overheard an argument between Resident B and LPN 1. The resident had wanted to increase his medication. He didn't feel LPN 1 would help him. The resident called LPN 1 a f---ing a-hole. LPN called Resident B a f---ing idiot. This made me upset. I wish I never saw it. I am ok now.An undated, handwritten document labeled as a verbal statement by Resident G, which was contained in the facility investigation file related to the 9/30/25 reported event, indicated he was seated in the hallway by the nurse's cart. He heard a bunch of cussing by a staff and a resident. He was surprised but not distressed. A 9/30/25, handwritten statement signed by C.N.A. 5, which was contained in the facility investigation file related to the 9/30/25 reported event, indicated they had completed patient care and came out of the room to hear LPN 1 yell F--- you it was the right f---ing dose at Resident B.A 9/30/25, handwritten statement signed by C.N.A. 6, which was contained in the facility investigation file related to the 9/30/25 reported event, indicated he witnessed LPN1 cuss at Resident B after the resident cursed at him. A 10/2/25, handwritten statement signed by QMA 4, which was contained in the facility investigation file related to the 9/30/25 reported event, indicated she had not worked the night of 9/30/25. However, she had made a written statement of concern about LPN 1 on a previous occasion.During an interview with the Administrator and DON on 11/14/25 at 2:30 p.m., they indicated they had no documented record of QMA 4 filling a concern regarding Resident H and withheld care due to bedbugs. They were aware of a bedbug concern, which ended up being cake crumbs. They had no documentation regarding an allegation of a concern (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding a statement to withhold care. The facility had looked into a concern about Resident E not being given pain medication in a timely manner. The record indicated the resident received his medication on time.During the same interview, they indicated LPN 1 was suspended during the investigation of the 9/30/25 allegation of verbal abuse. He resigned as a result. The results of the investigation indicated LPN 1 would have been terminated had he not resigned. An Employee Communication Form, which was provided by the Administrator on 11/24/25 at 2:42 p.m., indicated LPN 1 had been suspended pending investigation of an event which occurred 9/30/25. The violated policy was Rude/unprofessional Behavior, discourteous treatment of a resident. LPN 1 ha resigned in response to the investigation. A current facility policy revised on June 2023, titled Abuse Prohibition, Reporting, and Investigation, which was provided by the Administrator in 11/24/25 at 3:04 p.m., indicated: Verbal Abuse-The use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to a resident or their family within their hearing distance. This citation relates to intake 2631871. 3.1-27(a)(b)