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	02/04/2026

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

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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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** [NAME] on observation, interview, and record review, the facility failed to protect residents' rights to be free from resident-to-resident physical abuse for 4 of 5 residents reviewed for abuse. (Residents C, D, E and F)Findings include:Resident B's clinical record was reviewed on 2/2/26 at 10:37 a.m. Diagnoses included dementia, hypertension, major depressive disorder, and anxiety. An 11/10/25, admission, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired with fluctuating levels of inattention and disorganized thinking observed during the assessment period. A current resident care plan indicated a 12/25/25 problem of Resident B may have threatened to hit or physically attack other residents. Resident B may also shove. Resident B may also have episodes of shoving, hitting, scratching. Interventions included 1/23/26 encourage fluids and make sure fluids are in reach, 1/16/26 added stop sign to keep others out of room, offer to take a walk, 1/15/26 likes to tinker per family - offer to disabling a remote, offer PVC pipes and fittings, 1/9/26 show pictures of grandchildren, and 12/25/25 listen and respond to or anticipate needs. Review of Resident B's progress notes indicated the following: 12/14/25 at 2:00 p.m. The resident pushed another resident out his personal space, causing the other resident to lose balance. Resident B was placed on 1-on-1 monitoring. 12/25/25 at 11:16 a.m. The resident was speaking to a male peer in the common area when a female resident walked near him. He turned and pushed her, causing her to fall and kicked her in the abdomen. The residents were separated and resident B was placed on 1-on-1 monitoring. 12/25/25 at 2:40 p.m. A referral was made to inpatient psychiatric care. 12/25/25 at 2:49 p.m. The resident was visiting with family, telling them everyone knows what he did, he is a child molester, and I guess I lost my temper. 12/26/26 at 3:25 a.m. The resident removed a plastic frame from the wall in his room. He remained on 1-on-1 supervision. 12/26/26 at 2:40 p.m. The resident was transported to inpatient psychiatric care. The resident returned to the facility on 1/5/26. (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 - Some	1/8/26 at 3:13 p.m. The resident threw his phone into the dining room at the wall and shouted expletives. 1/8/26 at 4:07 p.m. His antipsychotic medication was increased and he was placed on 15-minute checks. 1/13/26 at 1:56 p.m. Resident B paced around another resident's room. 1/15/26 at 7:45 a.m. Resident B reportedly shoved another resident causing a fall. 1/15/26 at 11:50 a.m. Interdisciplinary Team (IDT) met with family to discuss behavioral expression. Family expressed interest in referral to a smaller facility. 1/16/26 at 10:27 a.m. Resident B wandered into other resident rooms. 1/17/26 at 6:26 a.m. Resident B was agitated in his room and said, I am going to break this place and have broken some hangers this time. 1/18/26 at 9:38 a.m. Resident B became agitated attempting to vocalize wants, pulling on other resident's wheelchairs, jerking, and yelling at staff members. 1/18/26 at 9:00 p.m. Resident B was pacing hallways, wandering in and out of other residents' rooms, and punching walls. He became aggressive with staff by drawing back his fist when staff attempted to use non-pharmacological redirection. 1/19/26 at 1:39 p.m. Resident's B's family requested a referral to inpatient psychiatric care. 1/19/26 at 1:40 p.m. Resident B was wandering in other resident rooms and shouted expletives when staff attempted to redirect him. He stood in the hallway picking at things in the air and on the floor that were not there. 1/23/26 at 1:16 a.m. Resident B threw his cup at his roommate, who was resting in bed. He was confused and mumbled incoherently when staff attempted to reorient him. 1/23/26 at 2:23 p.m. Resident B was pushing dining room chairs across the floor. When staff attempted to redirect told staff, I'll rip your f**king head off. 1/23/26 at 2:37 p.m. The IDT was aware of resident behaviors such as wandering, throwing items, pushing and throwing dining room chairs. Staff attempted multiple interventions without success. 1/23/26 at 6:34 p.m. Resident B pushed another resident against the wall in the hallway, creating a laceration to the right side of the other resident's head and bruising to her right shoulder. The physician was notified and the resident was transferred to the emergency room (ER). 1/29/26 at 11:53 a.m. The IDT met to review the resident's chart. Resident B was transferred to inpatient psychiatric services on 1/28/26. Resident B remained out of the facility during the survey dates. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 12/25/25 facility reported incident, submitted to IDOH (Indiana Department of Health) indicated Resident B was having a conversation with a male peer in the common area of the dementia unit when Resident E passed by them. Resident B turned toward Resident E and pushed her, resulting in a fall. No injury was reported. Preventative measures included monitoring residents for psychosocial distress. Resident B was placed on 1:1 care. Residents will remain separated during meals and activities. Root cause was to be determined. Follow up, included on 12/29/25, indicated Resident B was transferred to inpatient psychiatric care for aggressive behavior. He suffered from dementia and believed the female resident was a male and a child molester. Staff and family were unable to redirect this delusion. Care plans were to be updated once updated information from psychiatry was obtained. All medications and non-pharmacological interventions were reviewed. A 1/23/26 at 7:18 p.m. facility reported incident to IDOH indicated, on 1/23/26, Resident B made contact with Resident C, causing her to hit her head on a door jamb. Resident C sustained a shallow laceration (a cut) and hematoma (bruising) to the side of her head. Action taken- Staff intervened promptly and separated the residents. Full body assessments were completed with no other apparent injuries not listed in the injury section. Resident B was placed on 1:1 observation. The residents will be kept separated during meals and activities. Resident B will be seen by facility psychiatric services. Root cause will be investigated and appropriate interventions will be put in place to help prevent further altercations. Follow up, included on 1/27/26, indicated Resident B remained in the hospital. The plan was to transfer from the hospital to an inpatient psychiatric unit when he was deemed stable for transfer. IDT will attempt to determine root cause and implement appropriate interventions. Resident C was recovering and had no lasting psychosocial issues. A document included in the facility investigation for the altercation between Residents B and E, titled 1/26/26 Behavior/High Risk Peer Review, indicated Resident B had previous incidents pushing other residents. 12/25/25 Resident B pushed Resident E causing her to have a fall. Per progress notes review, 1/15/26 resident B shoved another resident causing them to fall. Resident B's clinical record lacked care plan interventions specific to mitigating the risk of Resident B engaging in resident-to-resident altercations. A 12/25/25 statement, signed by Housekeeper 25, indicated she observed Resident B acting aggressive about some pants he was holding. Resident E walked by, into the dining room. The housekeeper heard a loud noise and observed Resident E on the ground. Staff were trying to get Resident B back, but he kicked Resident E, so she ran in between them and stood over Resident E. Resident B tried to kick again, and staff took him down the hall and shut the big door. During an interview on 2/2/26 at 4:05 p.m., RN 4 indicated, on 1/23/26, she observed Resident B push Resident C against a wall. Resident B looked mad and aggressive. Resident B was previously on 15-minute checks and 1-on-1 care due to previous aggressive behaviors toward Residents E and F. During a telephone interview on 2/2/26 at 4:35 p.m., CNA 5 indicated Resident B frequently became overstimulated around other residents on the dementia unit. On 1/23/26, he was teetering with his emotions and staff would leave him alone, in an effort to not trigger him. She and CNA 19 were performing patient care and Resident C approached them and said there was a man in another man's room. The CNAs went down the hallway and Resident B came out of a room with an aggressive look on his face, so CNA 5 and CNA 19 put Resident C in front of them and began walking away from Resident B. Resident B then pushed CNA 5 and pushed Resident C into the wall. CNA 5 covered Resident C with her body, then several staff entered the dementia unit. The residents were separated and a fire door between the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	main area of the unit and resident rooms were closed to further separate the two residents. CNA 22 was heard shouting that Resident D was on the floor of his room. During the days prior to this incident, Resident B was intermittently on 1-on-1 care. During an interview on 2/4/26 at 4:11 p.m. the Administrator indicated he was notified by phone by RN 8 of an altercation with Residents B and C. Resident C approached CNA 5, stating two residents were going at it. 1.Resident E's clinical record was reviewed on 2/3/26 at 9:52 a.m. Diagnoses included dementia, generalized anxiety disorder, and mild neurocognitive disorder due to known physiological condition. A 12/16/25, quarterly, MDS assessment indicated the resident was severely cognitively impaired. Review of the resident's current care plan, last reviewed/revised on 12/22/25, indicated a 4/17/23 problem of the resident is at risk for falls due to impaired mobility, respiratory failure, sepsis, pneumonia, medications, and age. Interventions included (12/15/25) encourage the resident to not be in others' personal space. A 12/14/25 at 2:01 p.m., Fall Event note indicated the following: Description: Resident lost balance, which caused the resident to fall onto the ground on buttocks. Was fall witnessed: no Describe what the resident was doing prior to the fall: Resident was walking down the hall, while approaching another resident, who then pushed resident out of his personal space which caused resident to lose balance. Position of resident when first observed after fall: Resident sitting on buttocks on floor, legs straight out in front of resident, back up against wall Resident/Witness statement of how fall occurred: Resident reports walking down the hallway when fall occurred. Interventions put in place to prevent another fall: Residents to be separated. Notifications: Physician and resident representative were notified 12/18/25 at 9:07 a.m. A 12/15/25 2:01 p.m. IDT Fall Review indicated the following: Date/Time of fall: 12/14/25 at 2:01 p.m. Resident was close to another resident and other resident pushed her, causing her to fall. No injuries sustained, no ER transfer, no change in condition were noted. Determined root cause for the fall was the resident being in another resident's personal space. Interventions included staff encouraging the resident to not be in other's personal spaces. A 12/25/25 at 11:00 a.m. Fall Event indicated the following: Description: Resident shoved and kicked by another resident Was fall witnessed: yes (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Is the resident on blood thinning medications: yes Describe what the resident was doing prior to fall: Resident was walking past another resident, when another resident shoved this resident to the floor (resident did not strike head) and kicked them. Position of resident when first observed after fall: Resident on floor having been shoved and kicked by the other resident and was sitting upright. Fall location: Dementia unit dining room Resident/witness statement of how fall occurred: Resident was walking past other resident, when other resident shoved resident to floor (resident did not strike head) and kicked resident. Interventions put in place to prevent another fall: Staff separated other resident from resident to create safe space for resident. Assess resident and noted no signs/symptoms of injury. Nurse Practitioner (NP) and contact notified. A 12/25/25 at 11:00 a.m. progress note indicated Resident E was walking past another resident when the other resident shoved her down and kicked her in the stomach. Resident E exhibited no signs/symptoms of injury. Resident E voiced no complaints, but was intermittently tearful. During a telephone interview on 2/3/26 at 4:47 p.m. CNA 21 indicated she was on duty and witnessed the altercation on 12/25/25 between Residents B and E. Resident B was sitting across from the dining room yelling at another resident on the other side of the dining room. Resident E walked into the dining room and was pushed by Resident B, causing her to fall. Then he kicked her in the stomach and had his fists drawn back and CNA 21 was able to get between them. She took Resident B to his room. She indicated she wrote out a statement for the altercation. During an interview on 2/2/26 at 4:05 p.m., RN 4 indicated Resident B had shown previous aggressive behaviors toward Resident E. 2.Resident F's clinical record was reviewed on 2/3/26 at 11:20 a.m. Diagnoses included vascular dementia with unspecified severity and other behavioral disturbance, psychotic disorder with delusions due to known physiological condition, and anxiety disorder. A 12/30/25, quarterly, MDS assessment, indicated the resident was severely cognitively impaired. No behaviors were present during the assessment period. A progress note, dated 1/16/26 at 12:57 p.m., indicated Resident F had a fall on 1/15/26 at 8:30 a.m. Resident F was pushed by another resident and lost her balance, resulting in a fall without injury. The determined root cause of the fall was loss of balance after being pushed. The interventions put in place to address the root cause of the fall included a stop sign placed on the doorway of the room she preferred to wander into. During an interview on 2/2/26 at 4:05 p.m., RN 4 indicated Resident B had shown previous aggressive behaviors toward Resident F. During an interview on 2/3/26 at 2:46 p.m., QMA 18 indicated Resident F was known to randomly enter other residents' rooms from time to time to offer them snacks that her family brought into the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility. QMA 18 was present on the dementia unit when there was an altercation between Resident B and Resident F on 1/15/26. QMA 18 exited from another room to the hallway when she heard the CNA yelling, Oh my gosh. QMA 18 observed Resident F on the floor in the hallway, on the opposite side of the hallway, directly across from Resident B's room. Resident B was known to have previous physical altercations with Resident E and previous verbal altercations with other residents. Resident B had been agitated. The aide explained to QMA 18 that Resident F walked up to the door of Resident B's room and Resident B pushed Resident F, resulting in a fall. QMA 18 was instructed to keep Resident B and Resident F separated the remainder of the shift on 1/15/26. During an interview on 2/3/26 at 4:08 p.m., RN 20 indicated she was working on a different unit on 1/15/26 when QMA 18 reported a fall to her for Resident F. She completed a fall event note and did not find any injuries for Resident F. During a telephone interview on 2/3/26 at 4:32 p.m., CNA 21 indicated she witnessed what happened on 1/15/26 between Resident B and Resident F. Resident F came out of her room and was walking by Resident B's room on his side of the hallway when Resident B stepped forward from his doorway. Resident B pushed Resident F pretty hard. This propelled Resident F across the hallway, where she hit into the wall and door on the other side, and landed on the floor on her buttocks and left side. CNA 21 immediately intervened by closing Resident B's door. During an interview, on 2/4/26 at 12:30 p.m., LPN 10 indicated, on 1/15/26, an aide came to get her due to an altercation that occurred on the Dementia Unit. LPN 10 observed Resident F on the floor in the hallway, just through the doorway between the Dementia Unit and the dementia unit dining room. Resident B was in his room with an aide. CNA 21 told LPN 10 when Resident F walked past Resident B's room, Resident B stepped out of his room and pushed Resident F which resulted in Resident F's fall. LPN 10 assessed Resident F. She did not assess Resident B. On 2/4/26 at 4:08 p.m., the Administrator indicated he was told that Resident B pushed Resident F and she fell because she went into his room. Resident F was not injured or in distress. Pushing residents down could be considered abusive depending on the circumstances. This instance was considered a behavior that needed reviewed when the same resident kept pushing other residents down. 3.Resident D's clinical record was reviewed on 2/2/26 at 3:16 p.m. Diagnosis included severe dementia without behavioral disturbance, psychotic disturbance, mood disturbance, schizophrenia, and anxiety disorder. A 1/14/26, quarterly, MDS assessment indicated the resident was moderately cognitively impaired. No behaviors were exhibited during the assessment period. The resident required a wheelchair for mobility. Resident D required partial assistance from staff for transfers. He did not have any falls since the prior assessment. Resident D's progress notes indicated the following: A progress note, dated 1/23/26 at 6:18 p.m., indicated a CNA notified the nurse that Resident D was sitting on the floor between the bed and the wheelchair. The resident stated another resident pushed him to the floor from the bed. The resident denied pain. No injuries were noted on assessment. On 1/24/26 at 10:21 p.m., Resident D was assessed related to a resident-to-resident altercation. Resident D reported the crazy man punched him in the head and then pushed him out of the wheelchair. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No injuries were found. On 1/26/26 at 1:47 p.m., an IDT note indicated the resident fell on 1/23/26 at 6:25 p.m. The resident stated another resident came into his room and pushed him to the floor. The resident was sitting upright on the floor beside the wheelchair with no injuries. An immediate intervention put into place at the time of the fall included: The resident chose to be assisted to bed. The intervention put into place to address the root cause of the fall included a stop sign to the resident's doorway to help detour other residents from entering the room. During an interview on 2/2/26 at 3:55 p.m., CNA 19 indicated she went into Resident D's room to check on him after Resident B was sent out to the hospital on 1/23/26. Resident D told CNA 19 some [NAME] came into his room, punched him in the back of his head while he was watching television in his wheelchair, then he fell from his chair after the individual hit him. On 2/2/26 at 4:39 p.m., RN 4 indicated she was working on the Dementia Unit on 1/23/26 when there was an altercation between Resident B and Resident C. The CNA explained to RN 4 that Resident B was seen coming from Resident D's room. RN 4 observed Resident D in his room on the floor. Resident D explained that Resident B shoved Resident D into the floor. She placed a note in the clinical record. During a telephone interview on 2/3/26 at 3:39 p.m., CNA 22 indicated he was called over to the Dementia Unit on 1/23/26 in the evening to assist with the aggressor, Resident B, for monitoring. CNA 22 observed Resident D sitting on the floor in Resident D's room. 4. Resident C's clinical record was reviewed on 2/2/26 at 1:39 p.m. Diagnoses included Alzheimer's disease and cognitive communication deficit. A late entry progress note dated 1/23/26 at 7:17 p.m. for 1/23/26 at 6:00 p.m., indicated the resident was involved in a physical altercation in the living area. The resident was pushed into a wall and struck on the right side of the head and has a laceration on the right side of the head and a bruise to her right shoulder. Staff immediately intervened and separated both residents. The resident was sent out to the Emergency Room. The charge nurse and POA were notified. During an interview on 2/2/26 at 3:55 p.m., CNA 19 indicated she was working on 1/23/26 along with CNA 5. At approximately 6:00 p.m. that day, Resident C came to CNA 19 and CNA 5 in the Dementia Unit dining area and reported to them that two men were in a room fighting. Before they got to Resident D's room, Resident B came out of Resident D's room. Resident B's fists were balled up, he was angry, and was headed towards CNA 5, CNA 19, and Resident C. CNA 5 and CNA 19 turned around and instructed Resident C to walk the other way towards the dining room. Resident B picked up the pace and caught up with them when they were near the doorway by the dining room. CNA 5 tried to shield resident C. Resident B grabbed Resident C and pushed her against the door jam. The aides yelled for assistance and the ADON helped separate Resident B from Resident C. Resident C suffered a bruise on her shoulder, a cut on her head, and was sent out. The ADON took Resident B down the Dementia Unit hallway and shut the door between the Dementia Unit and the dining room. CNA 19 and CNA 5 tried to go back down the Dementia Unit to Resident D's room to follow up on Resident C's report of fighting and they were redirected by the ADON to go back to the dining room. CNA 22 was called to the Dementia Unit to assist with monitoring Resident B on the Dementia Unit. When CNA 22 went down the unit hallway and stated Resident D was on the floor. During an interview on 2/4/26 at 1:17 p.m., the ADON indicated she had stopped on the Dementia Unit (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	will be forwarded to the Long-Term Care Division of the Indiana State Department of Health. Copies of the completed investigation will also be sent to Adult Protective Services.10. It is the responsibility of every employee of American Senior Communities to report abuse situations, but also suspicion of abuse and unusual observations and circumstances to his/her immediate supervisor and to the Executive Director.13. The Executive Director will follow the reporting guidance delineated through the Indiana State Department of Health, Division of Long-Term Care Incident Reporting Policy This citation relates to intake 2727422. 3.1-27(a)(1)

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	02/04/2026

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

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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. Based on interview and record review, the facility failed to report allegations involving abuse immediately to the Administrator and to the State Agency (Indiana Department of Health) as required for 2 of 5 residents reviewed for abuse. (Residents D and F)Findings include:Resident B's clinical record was reviewed on 2/2/26 at 10:37 a.m. Diagnoses included dementia, hypertension, major depressive disorder, and anxiety.An 11/10/25, admission, Minimum Data Set (MDS) indicated the resident was severely cognitively impaired with fluctuating levels of inattention and disorganized thinking observed during the assessment period.A current resident care plan indicated a 12/25/25 problem of Resident B may have threatened to hit or physically attack other residents. Resident B may also shove. Resident B may also have episodes of shoving, hitting, scratching. Interventions included 1/23/26 encourage fluids and make sure fluids are in reach, 1/16/26 added stop sign to keep others out of room, offer to take a walk, 1/15/26 likes to tinker per family - offer to disabling a remote, offer PVC pipes and fittings, 1/9/26 show pictures of grandchildren, and 12/25/25 listen and respond to or anticipate needs.Review of progress notes indicated the following:On 1/15/26 at 7:45 a.m., Resident B reportedly shoved another resident causing a fall.On 1/23/26 at 6:34 p.m., Resident B pushed another resident against the wall in the hallway, creating a laceration to the right side of the other resident's head and bruising to her right shoulder. The physician was notified and the resident was transferred to the emergency room (ER).Resident F's clinical record was reviewed on 2/3/26 at 11:20 a.m. Diagnoses included vascular dementia with unspecified severity and other behavioral disturbance, psychotic disorder with delusions due to known physiological condition, and anxiety disorder.A progress note, dated 1/16/26 at 12:57 p.m., indicated Resident F had a fall on 1/15/26 at 8:30 a.m. Resident F was pushed by another resident and lost her balance, resulting in a fall without injury. The determined root cause of the fall was loss of balance after being pushed. The interventions put in place to address the root cause of the fall included a stop sign placed on the doorway of the room she preferred to wander into.During an interview on 2/4/26 at 3:34 p.m., the DON indicated she was made aware of a resident-to-resident altercation between Resident B and Resident F, but she could not recall when it was reported or who reported it to her. She assumed she heard about it when she got to the facility. During an interview on 2/4/26 at 4:08 p.m., the Administrator indicated a resident-to-resident altercation between Resident B and Resident F was reported to him, but he was uncertain who reported it or when it was reported. He was told Resident B pushed Resident C and she fell because Resident C went into Resident B's room. The resident was not in distress and did not have any injuries. The altercation was not reported to IDOH because it did not meet the facility's guidance to do so. Residents pushing other residents down could be considered abuse, depending on the circumstances. When the same resident kept pushing other residents down, it was a behavior that needed to be looked at. He reviewed the statements from staff. The staff typically reported abuse and resident-to-resident altercations to the charge nurse. Then the charge nurse reported to the Administrator. If staff chose to, all of them may report the abuse and resident-to-resident altercations to the Administrator.Resident D's clinical record was reviewed on 2/2/26 at 3:16 p.m. Diagnosis included severe dementia without behavioral disturbance, psychotic disturbance, mood disturbance, schizophrenia, and anxiety disorder.A progress note, dated 1/23/26 at 6:18 p.m., indicated a CNA notified the nurse that Resident D was sitting on the floor between the bed and the wheelchair. The resident stated another resident pushed him to the floor from the bed. The resident denied pain. No injuries were noted on assessment. The ADON was made aware.On 1/24/26 at 10:21 p.m., Resident D was assessed related to a resident-to-resident altercation. Resident D reported the crazy man punched him in the head (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and then pushed him out of the wheelchair. No injuries were found.On 1/26/26 at 1:47 p.m., an Interdisciplinary Team note indicated the resident fell on 1/23/26 at 6:25 p.m. The resident stated another resident came into his room and pushed him to the floor. The resident was sitting upright on the floor beside the wheelchair with no injuries. An immediate intervention put into place at the time of the fall included: The resident chose to be assisted to bed. The intervention put into place to address the root cause of the fall included a stop sign to the resident's doorway to help detour other residents from entering the room.During an interview on 2/2/26 at 3:55 p.m., CNA 19 indicated, on 1/23/26 at approximately 6:00 p.m., a resident reported to her that two men were fighting down the hallway. The CNA followed the resident toward Resident D's room and she observed Resident B coming out of Resident D's room, with his fists balled up and an angry expression on his face. The CNA was pulled away before she could check on Resident D, because Resident B grabbed the reporting resident and pushed her against the door jamb. Following this altercation, she headed back towards Resident D's room but was instructed by the ADON to go to the dining room to assist. CNA 19 then heard CNA 22 indicate that Resident D was on the floor. Resident D later reported to CNA 19 that some dude came into his room, punched him in the back of the head while he was watching TV while seated in a wheelchair, causing him to fall from the wheelchair. This allegation was not reported to the Administrator or DON.During a telephone interview on 2/3/26 at 3:39 p.m., CNA 22 indicated he was called over to the Dementia Unit on 1/23/26 in the evening to assist with Resident B, who was being aggressive with other residents. When CNA 22 rounded up Resident B, he noticed Resident D was sitting on the floor in Resident D's room. He then alerted RN 4 and the ADON that Resident D was on the floor.During an interview, RN 4 indicated, on 1/23/26, she observed Resident D on the floor in his room, when she went to check on him following a report of Resident B being seen leaving Resident D's room. Resident D indicated to RN 4 that Resident B had shoved him to the floor. RN 4 assessed him for injuries, found none, and entered a progress note into the clinical record. RN 4 did not report the allegation to the Administrator since RN 8 spoke with the Administrator.On 2/4/26 at 4:08 p.m., the Administrator indicated RN 8 had notified him on 1/23/26 at 6:05 p.m. of a resident-to-resident altercation between Resident B and Resident C and Resident D alleged he had been pulled out of bed. The Administrator was aware, in two of the statements provided in the facility investigation, of the altercation between Resident B and Resident C, and that Resident C had reported to the aides that two male residents were going at it down the hallway. Resident D was not included in the report to the Indiana Department of Health (IDOH) because Resident D did not have any injuries and he was not upset. Resident D was also known to embellish things and had inconsistencies in what he reported. It was not a reportable incident and the facility believed the two events were unrelated.A current facility policy, revised 6/2023, titled Abuse Prohibition, Reporting, and Investigation, provided by the Administrator on 2/2/26 10:37 a.m., indicated the following: .It is the policy . to provide each resident with an environment that is free from abuse. Identification: Abuse includes: .2. Resident to resident abuse of any type.Investigation: The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed.Resident to Resident Abuse: .9. It is the responsibility of the Administrator/Director of Nursing to report the abuse, or allegations of abuse, immediately, within 2 hours to the Indiana State Department of Health via the IDOH (Indiana Department of Health) gateway system Reporting/Response: 1. All abuse allegations must be reported to the Executive Director immediately.2. The Executive Director will ensure that if the alleged violation involves abuse or results in serious bodily injury, it must be reported immediately.10. It is the responsibility of every employee. to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report abuse situations, but also suspicion of abuse and unusual observations and circumstances to his/her immediate supervisor and to the Executive Director.13. The Executive Director will follow the reporting guidance delineated through the Indiana State Department of Health, Division of Long-Term Care Incident Reporting Policy.Cross reference F600.This citation relates to Intake 2727422.3.1-28(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to complete thorough and accurate investigations of resident-to-resident abuse to mitigate risk to other residents for 5 of 5 residents reviewed for abuse. (Resident B, Resident C, Resident D, Resident E, and Resident F.)Findings include:Resident B's clinical record was reviewed on 2/2/26 at 10:37 a.m. Diagnoses included dementia, hypertension, major depressive disorder, and anxiety.A current resident care plan indicated a 12/25/25 problem of Resident B may have threatened to hit or physically attack other residents. Resident B may also shove. Resident B may also have episodes of shoving, hitting, scratching. Review of Resident B's progress notes indicated the following:12/14/25 at 2:00 p.m. The resident pushed another resident out his personal space, causing the other resident to lose balance. Resident B was placed on 1-on-1 monitoring.1/15/26 at 7:45 a.m. Resident B reportedly shoved another resident causing a fall.1/23/26 at 6:34 p.m. Resident B pushed another resident against the wall in the hallway, creating a laceration to the right side of the other resident's head and bruising to her right shoulder. The physician was notified and the resident was transferred to the emergency room (ER).1.Resident E's clinical record was reviewed on 2/3/26 at 9:52 a.m. Diagnoses included dementia, generalized anxiety disorder, and mild neurocognitive disorder due to known physiological condition.A 12/16/25, quarterly, MDS assessment indicated the resident was severely cognitively impaired.Review of the resident's current care plan, last reviewed/revised on 12/22/25, indicated a 4/17/23 problem of the resident is at risk for falls due to impaired mobility, respiratory failure, sepsis, pneumonia, medications, and age. Interventions included (12/15/25) encourage the resident to not be in others' personal space.A 12/14/25 at 2:01 p.m., Fall Event note indicated the following:Description: Resident lost balance, which caused the resident to fall onto the ground on buttocks.Was fall witnessed: noDescribe what the resident was doing prior to the fall: Resident was walking down the hall, while approaching another resident, who then pushed resident out of his personal space which caused resident to lose balance.Position of resident when first observed after fall: Resident sitting on buttocks on floor, legs straight out in front of resident, back up against wallResident/Witness statement of how fall occurred: Resident reports walking down the hallway when fall occurred.Interventions put in place to prevent another fall: Residents to be separated.Notifications: Physician and resident representative were notified 12/18/25 at 9:07 a.m.A 12/15/25 2:01 p.m. IDT Fall Review indicated the following: Date/Time of fall: 12/14/25 at 2:01 p.m. Resident was close to another resident and other resident pushed her, causing her to fall. No injuries sustained, no ER transfer, no change in condition were noted. Determined root cause for the fall was the resident being in another resident's personal space. Interventions included staff encouraging the resident to not be in other's personal spaces.2.Resident F's clinical record was reviewed on 2/3/26 at 11:20 a.m. Diagnoses included vascular dementia with unspecified severity and other behavioral disturbance, psychotic disorder with delusions due to known physiological condition, and anxiety disorder.A 12/30/25, quarterly, MDS assessment, indicated the resident was severely cognitively impaired. No behaviors were present during the assessment period.A progress note, dated 1/16/26 at 12:57 p.m., indicated Resident F had a fall on 1/15/26 at 8:30 a.m. Resident F was pushed by another resident and lost her balance, resulting in a fall without injury. The determined root cause of the fall was loss of balance after being pushed. The interventions put in place to address the root cause of the fall included a stop sign placed on the doorway of the room she preferred to wander into.3.Resident D's clinical record was reviewed on 2/2/26 at 3:16 p.m. Diagnosis included severe dementia without behavioral disturbance, psychotic disturbance, mood disturbance, schizophrenia, and anxiety disorder.A 1/14/26, quarterly, MDS assessment indicated the resident was moderately cognitively impaired. No behaviors were (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	exhibited during the assessment period. The resident required a wheelchair for mobility. Resident D required partial assistance from staff for transfers. He did not have any falls since the prior assessment. Resident D's progress notes indicated the following:A progress note, dated 1/23/26 at 6:18 p.m., indicated a CNA notified the nurse that Resident D was sitting on the floor between the bed and the wheelchair. The resident stated another resident pushed him to the floor from the bed. The resident denied pain. No injuries were noted on assessment.On 1/24/26 at 10:21 p.m., Resident D was assessed related to a resident-to-resident altercation. Resident D reported the crazy man punched him in the head and then pushed him out of the wheelchair. No injuries were found.On 1/26/26 at 1:47 p.m., an IDT note indicated the resident fell on 1/23/26 at 6:25 p.m. The resident stated another resident came into his room and pushed him to the floor. The resident was sitting upright on the floor beside the wheelchair with no injuries. An immediate intervention put into place at the time of the fall included: The resident chose to be assisted to bed. The intervention put into place to address the root cause of the fall included a stop sign to the resident's doorway to help detour other residents from entering the room.Review of the facility's investigation files, provided by the Administrator following entrance conference, lacked investigations for the resident to resident abuse of Resident E, Resident F, and Resident D by Resident B. During an interview on 2/2/26 at 3:54 p.m., the Administrator indicated the entirety of the facility investigations was included in the files and all abuse investigations for the past 60 days had been provided. During an interview, on 2/4/26 at 4:08 p.m., the Administrator indicated a resident-to-resident altercation that occurred on 1/15/26 between Resident B and Resident F was reported to him. He was uncertain who reported it to him and when it was reported. He was told that Resident B pushed Resident F and Resident F fell because she went into Resident B's room. Resident F was not injured or in distress. Pushing residents down could be considered abusive depending on the circumstances. It was considered a behavior that needed reviewed when the same resident kept pushing other residents down. Cross reference F600. This citation relates to Intake 2727442.3.1-28(d)