STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Indianapolis, The	3895 S Keystone Ave Indianapolis, IN 46227

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. (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	Based on interview and record review, the facility failed to protect a resident's right to be free from sexual abuse for 1 of 3 residents reviewed for abuse. A male resident was observed leaving a female resident's room. The female resident indicated the male resident touched her breast. (Resident B, Resident C) Findings include:On 12/30/25 at 9:09 a.m., the Director of Nursing (DON) provided a copy of a facility reportable incident, dated 12/5/25 at 12:30 p.m. A review of the reportable incident brief description indicated Resident C made an allegation that Resident B touched her breast.During an interview on 12/31/25 at 8:15 a.m., Resident C was unable to describe the details of a sexual abuse allegation that she made against Resident B. Resident C repeated the word fine after each question of the interview. The clinical record for Resident B was reviewed on 12/31/25 at 9:02 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, hemiplegia that affected his right side, and diabetes.An annual Minimum Data Set (MDS) assessment, dated 9/27/25, indicated Resident B was moderately cognitively impaired.A care plan, dated 12/5/25, indicated Resident B exhibited sexually inappropriate behavior of touching and grabbing toward a cognitively impaired resident that lacked the ability to consent.A nursing communication form, dated 12/5/25 at 12:30 p.m., indicated Resident B exhibited sexually behaviors. Resident B had been placed on one-on-one observation and his medication had been reviewed.The clinical record of Resident C was reviewed on 12/31/25 at 9:49 a.m. The diagnoses included, but were not limited to, hemiplegia, aphasia (a communication disorder affecting speaking), dementia, and contracture of her right hand.A quarterly Minimum Data Set (MDS) assessment, dated10/7/25, indicated Resident C was moderately cognitively impaired.A progress note, dated 12/5/25 at 1:33 p.m., indicated Resident C had been sent to the emergency department due to physical aggression from another resident.During an interview on 12/31/25 at 10:32 a.m., RN 1 indicated she was the nurse caring for Resident C, on 12/5/25, when Resident C made an allegation of sexual abuse against Resident B. CNA 1 reported to RN 1 that she heard Resident C yelling no, so CNA 1 entered Resident C's room. Resident B was in her room and was escorted out and back to his room which was just across the hallway from Resident C's room. When RN 1 entered Resident C's room, she observed Resident C lying in bed with the left side of her brief unfasted. Resident C indicated to RN 1 that a man entered her room and touched her then pointed at her breast. Since Resident C's brief was unfastened, RN 1 asked if Resident B touched her anywhere else other than her breast and Resident C indicated no. This was the first time RN 1 had ever been made aware of any abuse allegations made against Resident B.During an interview on 12/31/25 at 10:42 a.m., CNA 1 indicated, on 12/5/25 at approximately 11:00 a.m., she was at the nurse's station and heard Resident C yelling out. As CNA 1 was walking toward Resident C's room, she observed Resident B wheeling out of Resident C's room and he indicated he had gotten lost. CNA 1 instructed Resident B that he was not supposed to be in a female resident's room. When CNA 1 entered Resident C's room, she observed Resident C lying in bed with the sheet pulled approximately halfway down the bed, her gown was pulled up, and her brief was unfastened on the left side and bent approximately halfway down in the front. CNA 1 thought this was suspicious because she had just changed Resident C's brief and repositioned her in bed. CNA 1 left Resident C as she found her and immediately went to get RN 1 so she could observe exactly what CNA 1 observed. When CNA 1 returned to Resident C's room with RN 1, Resident C was observed with the sheet pulled approximately halfway down the bed, her brief unfastened on the left side and bent approximately halfway down in the front. There had been no changes in the way Resident C had been observed by CNA 1 initially. When RN 1 asked Resident C if she had been touched, Resident C was unable to verbalize what had happened but was able to point at her breast.On 12/30/25 at 9:09 a.m., the DON provided a copy of a facility policy, titled Abuse Prevention Program, dated 10/22/22, and indicated this was the current policy used by the facility. A review of the policy indicated it was the policy of the facility to prevent abuse.This citation relates to Intake 2686747.3.1-27(a)(1)

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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 ensure a full description of an allegation of sexual abuse was reported to the state health department for 1 of 3 residents reviewed for abuse. A male resident was observed leaving a female resident's room. The female resident was found lying in her bed with the sheet pulled down, her brief unlatched on one side and bent down in the front, and her gown pulled up. (Resident B, Resident C) Findings include:On 12/30/25 at 9:09 a.m., the Director of Nursing (DON) provided a copy of a facility reportable incident, dated 12/5/25 at 12:30 p.m. A review of the reportable incident brief description indicated Resident C made an allegation that Resident B touched her breast.During an interview on 12/31/25 at 8:15 a.m., Resident C was unable to describe the details of a sexual abuse allegation that had been made against Resident B. Resident C repeated the word fine after each question of the interview. On 12/31/25 at 8:30 a.m., the DON provided a copy of a written statement from CNA 1, dated 12/5/25 at 11:50 a.m. (approximately 1 hour prior to the facility reportable incident being submitted), and indicated this was a written statement regarding the allegation of sexual abuse made by Resident C against Resident B. A review of the written statement indicated CNA 1 was at the nurse's station when she heard Resident C yelling. As CNA 1 was walking toward Resident C's room, she observed Resident B wheeling out of Resident C's room. CNA 1 asked Resident B why he was in Resident C's room and educated him that he should not be in a female resident's room. When CNA 1 walked in Resident C's room, Resident C's gown was pulled up, sheet off of her, and brief was open. CNA 1 immediately got RN 1. During an interview on 12/31/25 at 10:32 a.m., RN 1 indicated she was the nurse caring for Resident C, on 12/5/25, when Resident C made an allegation of sexual abuse against Resident B. CNA 1 reported to RN 1 that she heard Resident C yelling no, so CNA 1 entered Resident C's room. Resident B was in her room and was escorted out and back to his room which was just across the hallway from Resident C's room. When RN 1 entered Resident C's room, she observed Resident C lying in bed with the left side of her brief unfasted. Resident C indicated to RN 1 that a man entered her room and touched her then pointed at her breast. Since Resident C's brief was unfastened, RN 1 asked if Resident B touched her anywhere else other than her breast and Resident C indicated no. During an interview on 12/31/25 at 10:42 a.m., CNA 1 indicated, on 12/5/25 at approximately 11:00 a.m., she was at the nurse's station and heard Resident C yelling out. As CNA 1 was walking toward Resident C's room, she observed Resident B wheeling out of Resident C's room and he indicated he had gotten lost. CNA 1 instructed Resident B that he was not supposed to be in a female resident's room. When CNA 1 entered Resident C's room, she observed Resident C lying in bed with the sheet pulled approximately halfway down the bed, her gown was pulled up, and her brief was unfastened on the left side and bent approximately halfway down in the front. CNA 1 thought this was suspicious because she had just changed Resident C's brief and repositioned her in bed. CNA 1 left Resident C as she found her and immediately went to get RN 1 so she could observe exactly what CNA 1 observed. When CNA 1 returned to Resident C's room with RN 1, Resident C was observed with the sheet pulled approximately halfway down the bed, her brief unfastened on the left side and bent approximately halfway down in the front. There had been no changes in the way Resident C had been observed by CNA 1 initially. When RN 1 asked Resident C if she had been touched, Resident C was unable to verbalize what had happened but was able to point at her breast. On 12/30/25 at 9:09 a.m., the DON provided a copy of a facility policy, titled Abuse Prevention Program, dated 10/22/22, and indicated this was the current policy used by the facility. A review of the policy indicated allegations of abuse must be reported.This citation relates to Intake 2686747.3.1-28(c)