STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warsaw Meadows	300 E Prairie St Warsaw, IN 46580

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 - 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warsaw Meadows	300 E Prairie St Warsaw, IN 46580

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 - Actual harm Residents Affected - Few	Based on observation, record review and interview, the facility failed to prevent physical and emotional abuse for 2 of 3 residents reviewed for abuse prevention. (Residents C & D) This deficient practice resulted in 1 of 3 residents sustaining extensive bruising (Resident C) and 2 of 3 residents experiencing mental anguish and fear. (Residents C & D)Findings include:1.A record review for Resident B was completed on 9/29/2025 at 10: 46 A.M. Diagnoses included, but were not limited to: schizophrenia, alcohol abuse, epilepsy, drug induced dyskinesia, major depressive disorder and mood disorder.A Quarterly MDS assessment, dated 9/29/2025, indicted Resident B was cognitively intact, transferred independently, received antipsychotic, antidepressant and anticonvulsant medication, had exhibited behaviors of physical behavioral symptoms for 1-3 days during the assessment period and verbal behavioral symptoms for 1-3 days of the assessment look back period. The current care plans for Resident B, revised on 5/30/2025, included the following plan: Resident is at risk for exhibiting behaviors related to Schizophrenia with history of behaviors. Behaviors exhibited are anger/yelling/cursing. The interventions included, but were not limited to: offer one on one attention with staff (added 9/23/2025 after the altercation), re-direct resident with a snack or an activity and the interdisciplinary team was to review the behavior management program every quarter and as needed. The current care plans for Resident B included the following: had a history of striking out at staff andpeers, initiate on 3/23/2023. The interventions included: At first sighs of agitation please remove from situation and provide a safe place for me to express what's bothering me and to make my feelings known, please offer me a snack such as popcorn, chips, and some tea.Review of a Trauma Evaluation Note, completed on 9/20/2025 at 8:38 P.M., and documented as late entry on 9/23/2025 at 4:10 A.M., indicated the residents were lined up by the courtyard door for their next cigarette break and Resident C was upset because she had not received her medications. Resident B had approached Resident C, who had been standing against the wall. Resident B had placed his wheelchair in front of Recent C and stated, I'm sick of listening to your f---ing mouth. Resident B then began hitting Resident C's upper body and head with his closed fists.A Nursing Progress Note, on 9/20/2025 at 8:45 P.M. and documented as a late entry on 9/23/2025 at 4:01 A.M., indicated the nurse had been notified by staff who had witnessed Resident B approach Resident C, stop his wheelchair in front of her and state, I'm sick of listening to your f---ing mouth and then had hit Resident C with clenched fists in her upper body, face and head. Resident B was taken to his room for a full body assessment and the notes indicated he had sustained a scratch down his face. A Nursing Progress Note, completed on 9/21/2025 at 7:40 P.M., indicated two police officers had interviewed Resident B about yesterday's incident. The note indicated Resident B had not been truthful with the police officers, per staff witnesses. Immediately after the police officers left the facility, Resident B went by Resident D, who had been trying to get to her room. Resident B had screamed at Resident D and stated, You need to mind your own f---ing business. The interaction had been observed by staff, who intervened immediately and redirected Resident B to his room and Resident D to her room.A Trauma Evaluation Note, completed on 9/22/2025 at 9:50 A.M., indicated Resident B had told the writer that he and Resident C were with other residents waiting in the hall to go out to smoke. Resident B indicated that Resident C had been talking very loudly about all kinds of negative stuff. Resident B indicated he made a comment to Resident C and Resident C had commented back to him and then had hit him on his head.A Social Service Note, completed on 9/22/2025 at 9:50 A.M., indicated Resident B had come to the office The Social Service Director (SSD) indicated she had asked the resident what had happened to his head. Resident B indicated he had gotten into a fight with Resident C. Resident B insisted Resident C had initiated physical contact and he had defended himself. A Social Service Note, on 9/22/205 at 11:13 A.M., indicated the SSD had called Resident B's mother and had gotten permission to send Resident B to a psychiatric hospital and a referral had been sent to the acute care facility. A Nursing Progress Note, on 9/22/2025 at 9:30 P.M., indicated the psychiatric hospital ambulance had arrived and had transported Resident B to the psychiatric hospital.During an interview, on 9/29/2025 at 8:47 P.M., Confidential Employee 2 indicated Resident B sometimes had physical altercations if he did not get his way. Confidential Employee 2 indicated the approach made a difference in his behaviors and the more praises he received, the better his attitude. Confidential Employee 2 indicated they were not at the facility on the evening of Resident B and Resident C's altercation. They indicated Resident B sometimes had a good night and sometimes had a bad night. Employee 2 indicated Resident C sometimes could flip the switch quickly and just be hateful.During an interview, on 9/29/2025 at 9:06 P.M.