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	12/31/2025

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 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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to implement their policy to report an allegation of verbal abuse in a timely manner for 1 of 3 residents reviewed for abuse, (Resident B). Finding includes:On 12/30/25 at 11:43 A.M., Resident B's clinical record was reviewed. Resident B was admitted to the facility on [DATE] with diagnoses that included but were not limited to dementia, anxiety, depression, benign brain tumor, age-related debility, low back pain, cognitive communication deficit, orthostatic hypotension, insomnia, muscle weakness. Review of a facility reported incident, Incident Number 652, indicated on 12/10/25 at 2:01 P.M., staff reported that Certified Nursing Assistant (CNA) 4, was overheard using profanity to tell Resident B to shut up while in the hallway of the Memory Care Unit. On 12/10/25 an investigation was initiated, and CNA 4 was removed from the schedule pending an investigation. A follow-up dated 12/15/25 indicated Resident B did not recall the event and the staff member involved was interviewed and denied the allegation. The report indicated CNA 4 indicated she said the statement to CNA 3, not to the resident. During an interview on 12/30/25 at 12:50 P.M., CNA 3 indicated just before the lunch meal, on 12/6/25, she and CNA 4 took Resident B to use the restroom. CNA 3 indicated Resident B was talking a lot and actively standing and sitting, not understating she was supposed to use the toilet. CNA 3 indicated that CNA 4 became frustrated with the resident and told the resident to shut the f--- up. CNA 3 indicated she then sent CNA 4 out of the room to gather supplies and she did not return to assist the resident after that. CNA 3 indicated she reported the incident, on 12/6/25 to Employee 5, who was the Weekend Manager. CNA 3 indicated she was aware that she was supposed to report allegations of abuse to the Administrator, but she neglected to do so. CNA 3 indicated she had not reported the allegation of verbal abuse to her Unit Manager. CNA 3 indicated on 12/10/25, she reported the allegation of verbal abuse to Employee 2 and to the Director of Nursing.During an interview on 12/30/25 at 1:13 P.M., Employee 2 indicated on 12/10/25, CNA 3 told her of an incident of verbal abuse that had allegedly occurred on 12/6/25 between Resident B and CNA 4. Employee 2 indicated she immediately notified the Administrator of the allegation of abuse as reported to her from CNA 3. On 12/31/25 at 10:07 A.M., during an interview, CNA 4 indicated she had helped CNA 3 toilet Resident B on 12/6/25, but did not curse at the resident at any time, but on 12/10/25 was sent home pending an investigation. During an interview on 12/31/25 at 10:16 A.M., Employee 5, indicated she was Manager on Duty on 12/6/25 and was never notified of an allegation of abuse at that time. Employee 5 indicated on 12/10/25, during a conversation, CNA 3 indicated she thought maybe CNA 4 might have cussed in front of or at a resident over the weekend. Employee 5 indicated she asked CNA 3 if she had reported the allegation to the Director of Nursing or the Administrator and CNA 3 indicated she had not. On 12/31/25 at 11:33 A.M., an interview with the Administrator indicated an alleged incident of verbal abuse had occurred on 12/6/25 when CNA 4 allegedly cursed at Resident B. The Administrator indicated the allegation was not reported to him until 12/10/25 by Employee 2. The Administrator indicated he immediately suspended CNA 3 pending an investigation, reported the allegation to the State Survey Agency, and initiated an investigation. The Administrator indicated he repeatedly reminds staff of the importance of reporting allegations of abuse to him immediately, but CNA 3 never reported an allegation of abuse to him at any time. On 12/30/25 at 11:50 A.M., the Administrator provided the policy, ABUSE POLICY, dated 9/22, indicating it was the facility's current abuse policy. The policy indicated, .The resident has the right to be free from abuse,.The facility must not use verbal.Abuse.includes verbal abuse, an allegation of abuse.will be reported immediately, but not later than: Two (2) hours if the alleged violation involves abuse.; or Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in bodily injury. This citation is related to Complaint 2691463.3. 1-28(c)