STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on observation, interview, and record review, the facility failed ensure residents were protected from sexual abuse when Resident B, who had moderate cognitive impairment, was found performing oral sex on Resident C, who had severe cognitive impairment and a known history of sexually inappropriate behaviors. The facility failed to assess the residents' capacity to consent to sexual activity prior to the incident and did not implement interventions in place to mitigate Resident C's sexually inappropriate behaviors. Using the reasonable person concept, it can be determined this deficient practice resulted in severe psychosocial harm, including dehumanization and humiliation for 1 (Resident B) of 2 residents (Resident C) of 5 residents reviewed for abuse.The immediate jeopardy began on 3/22/26 when Resident B was found performing oral sex on Resident C, who was known to exhibit sexually inappropriate behaviors. The acting Administrator, DON, and Nurse Consultant were notified of the immediate jeopardy on 3/27/26 at 1:42 p.m. The immediate jeopardy was removed on 3/28/26, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy.Findings include:Resident B's clinical record was reviewed on 3/26/26 at 9:44 a.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, single episode, and cognitive communication deficit.A 1/31/26 admission Minimum Data Set (MDS) assessment indicated she had moderate cognitive impairment and no behaviors were exhibited. Her medications included donepezil hydrochloride (treat dementia) 10 milligram (mg) daily.She had a current order, dated 1/28/26, for behavior monitoring every shift related to signs and symptoms of depression, tearfulness, or self-isolation. Interventions included attempting redirection, snack, offering fluid, an activity for diversion, toileting, changing environment, pain assessment, offering a nap or rest period, and providing comfort measures. A current care plan, revised 1/30/26, indicated a problem of impaired cognition/function or impaired thought process related to dementia with poor short and long-term memory. Interventions included cuing, reorientation, and supervision as needed (1/28/26), presenting one thought, idea, question or command at a time (1/28/26), and using task segmentation to support short term memory deficits, and break tasks into one step at a time (1/28/26).A current care plan, dated 2/2/26, indicated a problem that she required the use of a position change alarm related to poor safety awareness and impulsiveness with attempts to stand or self-transfer without assistance despite repeated direction, verbal cues and/or re-education.A current care plan, created on 3/20/26 and revised on 3/23/26, for the promotion of Safe Practices (Intimate/ Sexual Relationships) indicated she was alert, aware, coherent, in choosing to exercise her right to engage in an intimate/sexual relationship. She enjoyed companionship with a male peer within the facility. She enjoyed social engagement which may include affectionate acts such as hand holding or putting her arm around the male peer. Interventions included acknowledging the residents' need for connection to make them feel valued (3/20/26), assessing her to determine her understanding of the nature of the act and her ability to refuse (3/20/26), encouraging appropriate touch such as hand holding, hugs, etc., if residents were being affectionate in a public setting, (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
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	offering privacy to ensure dignity was maintained (3/20/26), encouraging participation in activities to reduce boredom which was often a reason for attention seeking (3/20/26), helping her maintain and preserve her dignity, integrity, and confidentiality by discussing these matters in a room that afforded privacy (3/20/26), offering psychosocial visits to ensure she continued to be comfortable with her level of interaction and interactions with male peers (3/20/26), and remind her that intimate/sexual partners must be able to provide consent and the consent must be mutual (3/20/26).A social service note, dated 3/20/26 at 2:52 p.m., indicated her Power of Attorney (POA) and Emergency Contact was notified regarding Resident B seeking companionship with a male resident of the facility. She ate meals with the male resident and sat in lounge with him. Resident B's representatives were both in agreement with Resident B's actions. The facility would continue to monitor the relationship.A nurses note, dated 3/21/26 at 10:35 p.m., indicated she had short- and long-term memory problems. She had moderate impairment with decisions regarding tasks of daily living. She was alert and oriented with occasional confusion noted. She continued with a pressure alarm due to poor safety awareness and needed reminders to use call light and wait for assistance with transferring and ambulating. She required the assistance of one staff member with ambulating with walker.A nurses note, dated 3/22/26 at 10:11 a.m., indicated she had short- and long-term memory problems. She had moderate impairment with decisions regarding tasks of daily living. She was alert to self and could recognize certain peers. She continued to self-transfer often, sounding her pressure alarm. Reminders were given about safety, but she had short term memory impairment. A Situation, Background, Assessment, Recommendation (SBAR) summary, dated 3/23/26 at 2:56 p.m., indicated she was being sent to the emergency room for an evaluation of sexual assault per facility protocol related to staff observation of Resident B performing oral sex on a male resident. The staff intervened and the male resident was directed out of her room. Close supervision was maintained to ensure the male resident did not re-enter her room.A nurse's note, dated 3/23/26 at 3:30 p.m., indicated Resident B was spoken to regarding the (oral sex) incident. She would not/could not talk about incident. She reported that she was friends with the male resident and that he lost his wife recently and they were lonely. She denied the male resident ever touching her in unwanted and inappropriate manner. She adamantly denied the male resident touching her in an unwanted manner.A nurse's note, dated 3/23/26 at 4:00 p.m., indicated at 2:00 p.m., staff reported observing Resident B in her room with a male resident, and Resident B performed oral sex on the male resident the previous evening. The staff asked the male resident to leave the room immediately; he was agitated but complied. Staff provided close monitoring to ensure the male resident did not re-enter the room. The Administrator, family, and physician were notified.A nurse's note, dated 3/23/26 at 8:15 p.m., indicated the hospital called and stated they would not perform the exam because they did not feel it was necessary for Resident B to go through the procedure and that the exam would be necessary only if legal action was pursued. A nurses note, dated 3/23/26 at 10:53 p.m. indicated Resident B returned to the facility.Resident C's clinical record was reviewed on 3/26/26 at 11:39 a.m. Diagnoses included unspecified dementia, mild, with other behavioral disturbance, and delusional disorders.A 1/25/26, quarterly, MDS assessment indicated he had severe cognitive impairment and no behaviors were exhibited. His medications on 3/22/26 included donepezil hydrochloride (medication to treat confusion and memory loss)5 mg daily (started 8/22/24) and risperidone (antipsychotic) 0.25 mg twice daily (started 3/5/26).He had a current order, dated 5/16/25, for behavior monitoring every shift related to delusions and paranoia, thoughts of his wife having an affair, self-picking of skin, insomnia, and difficulty sleeping. Interventions included attempting redirection, snack, offering fluid, an activity for diversion, toileting, changing environment, pain assessment, offering a nap or rest period, and providing comfort measures. A resolved care plan, created on 11/21/25 and resolved on 1/21/26, indicated a problem of inappropriate personal boundaries. He demonstrated behavior symptoms concerning inappropriate personal boundaries due to cognitive impairment secondary to Alzheimer's disease or dementia. The symptoms were manifested by inappropriate touching (i.e., attempting to rub another person's back, reaching for a leg, shoulder (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	rubbing or bump). His goals included that he would refrain from making inappropriate remarks (resolved 1/21/26), he would demonstrate respect for personal boundaries during interaction with staff and peers (resolved 1/21/26), he would ask appropriate questions (resolved 1/21/26), he would behave with respect towards staff and peers (resolved 1/21/26), documenting, as appropriate, behavior symptoms such as disrespecting boundaries and assertively communicating to him that each person was expected to behave with dignity and respect (resolved 1/21/26), staff needed to be assertive when interacting with people who did not respect boundaries. It was important to: (A) establish clear boundaries, (B) reinforce the boundaries, do not waiver, do not show flexibility; enforce strict limits, (C) communicate how to set these limits with fellow staff members and (D) communicate how to handle this behavior to him, who were approached by peers, who did not respect boundaries (resolved 1/21/26), using phrases to clearly communicate what behavior was unacceptable and inappropriate, for example: Assertively tell him to respect your personal space and step back prior to speaking with you and I am concerned about your wellbeing and I will help you function at your best. (resolved 1/21/26)A current care plan, dated 1/21/26, indicated he had a companionship with some female peers within the facility. He enjoyed social engagement which may include affectionate acts such as hand holding or putting his arm around female peers. His goal was that he would exercise safe, respectful and appropriate practices, and his preference for social engagement/personal touch with female peers would be honored through next review. (1/21/26) Interventions included acknowledging the residents' need for connection to make them feel valued (1/21/26), assessing him to determine his understanding of the nature of the act and his ability to refuse (1/21/26), encouraging appropriate touch such as hand holding, hugs, etc. If residents were being affectionate in a public setting, offering privacy to ensure dignity was maintained (1/21/26), encouraging participation in activities to reduce boredom which was often a reason for attention seeking (1/21/26), helping him maintain and preserve his dignity, integrity and confidentiality by discussing these matters in a room that affords privacy (1/21/26), offering psychosocial visits to ensure that he continued to be comfortable with his level of interactions with female peers (1/21/26).A nurses note, dated 7/31/25 at 10:50 a.m., indicated Resident C was noted to have increased friendliness towards female residents (patting arms and hand holding). Education and re-enforcement on appropriate behaviors was provided to Resident C. The Nurse Practitioner (NP) recommended starting medroxyprogesterone (used in men to manage aggressive, sexually inappropriate behaviors in patients with dementia). The physician and the family agreed. A social service note, dated 8/7/25 at 9:56 a.m., indicated it was reported Resident C was sitting on his rollator walker in front of a female resident talking in a female resident's room. He indicated that they were talking, then got up, and indicated that it was time to go. The female resident was asked if she was ok and comfortable. The female resident indicated that they were just talking. A nurse's note, dated 8/25/25 at 12:46 p.m., indicated he was visiting in another resident's room, and when asked to leave the room, he became agitated and cursed at staff. He remained friendly. He frequently used his hands when talking with staff and residents. He touched hands and rubbed arms, etc. He indicated that he always used his hands to talk and was able to get his point across when he used his hands and felt it was respectful. He was unable to understand he shouldn't touch other residents, even in a friendly innocent manner, and not all residents were able to make decisions for themselves. No improvement was noted since starting medroxyprogesterone. New orders were received to increase the medroxyprogesterone to 15 mg daily.A nurse's note dated 10/2/25 at 10:37 a.m. indicated Interdisciplinary (IDT) behavior meeting recommended to decrease his medroxyprogesterone. A nurse's note, dated 1/21/26 at 9:43 a.m., indicated the resident sought companionship with another female resident. The residents sought each other out and the relationship was mutual. His care plan was updated.A care plan meeting note, dated 1/26/26 at 10:15 a.m., indicated that he was alert to self and place. He sought companionship with female residents. He enjoyed spending time talking and holding hands. His family was aware and in agreement. His care plan was appropriate.An IDT note, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	dated 2/3/2026 at 7:51 p.m., indicated he continued with his usual affect, daily routine, and seeking out female companionship. He had no signs or symptoms of delusions, irritability, or social withdrawal. He was due for a gradual dose reduction (GDR) of medroxyprogesterone. IDT recommended decreasing to 5 mg daily.An IDT note, dated 3/11/26 at 12:51p.m., indicated the pharmacist recommended discontinuing the medroxyprogesterone. The physician and IDT agreed to discontinue. The resident continued with his usual routine but decreased interaction with other female residents. The IDT would continue to monitor.His medication history indicated he received medroxyprogesterone acetate for hypersexuality (persistent sexual impulses). He had the following medication adjustments related to medroxyprogesterone acetate:On 8/1/25, he was started on 10 mg that was discontinued on 8/25/25. On 8/26/25, the medication was increased to 15 mg and was discontinued on 10/2/25. On 10/2/25, the medication was decreased to 10 mg and was discontinued on 2/5/26. On 2/6/26, the medication was decreased to 5 mg and was discontinued on 3/12/26. A social service note, dated 3/18/26 at 12:31p.m., indicated he was observed holding hands with a female resident in the central lounge after breakfast, then observed talking with different female resident in main dining room after lunch.A social service note, dated 3/19/26 at 8:57 a.m., indicated he had increased aggravation when staff attempted to redirect or orientate him. Yesterday afternoon, he was visiting with another female resident in the main dining room and began to get angry with staff because they would not leave them alone. The female resident required assistance and could walk by herself. A social service note, dated 3/19/26 at 9:33 a.m., indicated the DON felt that Resident C was failing his GDR of medroxyprogesterone due to increased interactions with female residents.A behavior note, dated 3/22/26 at 3:20 p.m., indicated that he had increased agitation and interactions with female peers. He was asked to visit females in the public lounge and not in their rooms. He became angry and said, I'll just fix this and angrily walked away, cursing at staff. Interventions were effective for a short moment. He had a short-term memory problem.A behavior note, dated 3/22/26 at 8:11 p.m., indicated he became very agitated with staff upon redirection from female residents. He had an inappropriate behavior with a confused female resident, and he was redirected from the room.A SBAR summary, dated 3/23/26 at 3:04 p.m., indicated staff observed Resident C in another female resident's room receiving oral sex. The staff immediately asked him to leave the room; he was agitated with leaving but did comply. Staff monitored closely to ensure that he did not re-enter the room or any other rooms. The provider was notified and recommended Resident B to be sent for a psychiatric evaluation and treatment. Fifteen-minute checks and one on one supervision were initiated until he could be sent for an evaluation.During an interview on 3/26/26 at 1:51 p.m. Qualified Medication Aide (QMA) 7 indicated, on 3/22/26 between 7:00 p.m. and 8:00 p.m., she was passing medication and as she walked by Resident B's room, Resident B's roommate was seated in her wheelchair in the hall, and she saw half of Resident C's body in Resident B's room. Resident C was standing in front of Resident B with his walker between him and her and his pants were partially down, exposing his buttocks. Resident B was seated in her recliner leaning forward and Resident C's right knee was propped up on the seat of his walker as he leaned forward towards Resident C. Resident B was performing oral sex on Resident C. QMA 7 asked Resident C to leave the room. He got mad, pulled up his pants and left the room. He asked why he had to leave and told QMA 7 that she thought she was the boss. Resident B really didn't say anything and after Resident C left. Resident B had forgotten that anything had happened. The QMA reported what she observed to the charge nurse, and they kept Resident C away from Resident B and other female residents. QMA 7 indicated that about a week ago, Resident B and Resident C began being fond of each other, but he did not normally go into her room. They sought each other out and held hands during activities and talked a lot. There were three other female residents that Resident C held hands with or rubbed their arm. Resident B and Resident C were both confused. Resident B had a positioning alarm due to unsteadiness, and she was not supposed to get up by herself.During an interview, on 3/26/26 at 2:32 p.m., Resident B's representative indicated the facility contacted them on 3/16/26 about Resident B holding hands, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	spending time with, and walking and talking with a male resident. The resident's representative told the facility that they were okay with just holding hands, but nothing else. The facility reassured them that nothing more would happen and staff would keep an eye on the residents. The resident representative was not happy with the situation and were completely thrown off guard by Resident B performing oral sex on Resident C. Resident B had moderate to severe dementia and didn't recognize family at times. She had thought her son was a soda salesman during a visit because he brought her a soda. Resident B often asked where she was and when she was going home. During an interview on 3/26/26 at 2:43 p.m. Registered Nurse (RN) 16 indicated QMA 7 reported to her that she observed Resident B performing oral sex on Resident C and had told Resident C to leave the room. Resident C told RN 16 that he might not be doing things right, but he was not as stupid as they thought he was. Resident C did not have much memory recall. RN 16 had seen Resident C sitting in the lounge with his penis out of his pants before and had asked a female resident to put their hands in his pants, which was his last girlfriend prior to Resident B. He would go into another female resident's room and lay in her bed and rub her arm. RN 16 did not feel those actions were inappropriate, but oral sex was inappropriate. When QMA 7 reported the observation, RN 16 did not report it to anyone, but she made a behavioral note. Staff had been told that it was okay for the residents to have a sexual relationship.During a follow up interview, on 3/26/26 at 3:27 p.m., Resident B's representative indicated performing oral sex was not normal behavior for Resident B. Resident B was very [NAME] and proper and always dressed to the nines. Resident B would never have done this. Resident B and Resident B's husband held hands or pecked on the lips. They were not ever even observed hugging. Resident B would be appalled to know this had happened, if she was not confused.During an interview, on 3/27/26 at 9:56 a.m., Resident G indicated she had a concern related to Resident C. She had heard in the halls and from staff that Resident C was doing things to female residents in the facility. She heard through staff and in the hallway that a female resident performed oral sex on Resident C. She was worried and fearful that he would come into her room and touch her, and she did not want to be touched. He had never come into her room and if he did, she would kick in his groin.Resident G's clinical record was reviewed on 3/30/26 at 10:34 a.m. Diagnoses included major depressive disorder, single episode.A 2/3/26, quarterly, MDS assessment indicated she was cognitively intact. During an interview, on 3/27/26 at 12:15 p.m., the DON indicated Resident C's care plan for inappropriate behaviors had been resolved due to the direction of the Long-Term Care Ombudsman. The Ombudsman told the facility it was the residents' right to have sexual contact, and it was not a maladaptive or inappropriate behavior.During an interview, on 3/27/26 at 12:22 p.m., the Psychiatric NP indicated, initially in September 2025, the facility was concerned with Resident C's sudden focus on female residents. He was rubbing their arms and inappropriately touching them. To prevent that from escalating, he started taking medroxyprogesterone. His dose was decreased then discontinued due to the Ombudsman indicating that it was appropriate for Resident C to hold hands and rub legs of other female residents. There was a discussion with him and the female residents involved at the time and the ability to consent. All three residents had dementia but were able to verbalize inappropriate touch or touch they didn't want. The NP felt that Resident C had the capacity to consent and believed he knew what he was doing. Resident B did not receive psychiatric services. The NP was not aware that Resident C was sent to an inpatient psychiatric hospital or that Resident C was involved in an oral sex incident. The facility staff had to redirect Resident C several times related to female residents. He would get agitated and if not redirected, it was not known what would happen. This is why prevention was important. Resident C's risperidone was decreased, then the NP was notified on 3/19/26 that the resident failed his dose reduction due to agitation related to increased promiscuity. The NP suggested that staff just monitor Resident C and to document the behaviors, since what was reported did not warrant increasing the risperidone or restarting the medroxyprogesterone.During an interview, on 3/27/26 at12:54 p.m. the acting Administrator indicated there was not any behavior documentation, as behaviors were monitored only if they were considered (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	maladaptive.During an interview, on 3/27/26 at 1:24 p.m., the acting Administrator indicated a Sexual Consent Capacity Assessment was not completed prior to the incident between Resident B and Resident C. An assessment was completed as part of the facility investigation.During an interview on 3/28/26 at 9:13 a.m., Resident B sat in her recliner in her room in a reclined position with a blanket covering her. She indicated that she was at the health department. She did not know what town she was in and did not know what year it was. She indicated there were no male residents who had been in her room and she did not have a male friend or boyfriend.During an interview on 3/28/26 at 10:44 a.m. Housekeeper 9 indicated Resident C would get touchy feely. He caressed the female resident's legs or around their breast area, and if you tried to separate him from the female resident, he would get hostile. The housekeeper reported her observations to the DON and other supervisors and had told the CNAs to watch him. About a month ago, she witnessed Resident C in Resident F's room. Resident C pulled Resident F's hand to his private area on the outside of his clothing. Another time, the housekeeper observed Resident C and Resident B in the dining room together after lunch, and Resident C was touching Resident B's breast. Housekeeper 9 reported the incident to her supervisor. During an interview on 3/30/26 at 9:43 a.m., the Social Service Director (SSD) indicated Resident C was social with everyone, male or female. He normally sat at the dining room drinking coffee and females gravitated toward him. Resident F walked around with him at times, and during her peak confusion, he would get slightly annoyed with her. She would ask Where do you want to go? and What do you want to do? Resident D sat in the lounge, and Resident C stopped to talk to her, and that was how their friendship developed. Resident E played BINGO with Resident F and they would argue who was going to sit with Resident C. Resident B sat at the dining table for meals and Resident B and Resident C started talking. The facility resolved care plans regarding sexual behaviors after speaking with the Ombudsman to determine whether the behaviors were inappropriate or the residents' rights. Resident C's hypersexuality increased with the number of females that he was making friends with. When Resident C was redirected, he was aggravated and asked why he could not talk to the female resident. He held hands and patted Resident E's and Resident D's legs. Resident C held hands with Resident B. The staff completed behavior tools and then the SSD would put a note in the electronic health record. The behavior sheets were located in a behavior tool folder at each nurse's station. The CNAs were unable to read the care plans in the health record but could see the behaviors on the behavior sheets. Resident C was on medroxyprogesterone, and psychotropic behavior monitoring would be located on the Medication Administration Record (MAR). The DON or ADON added the psychotropic medication monitoring to the MARs. The behaviors were reviewed monthly. The behaviors were a fine line between being appropriate or infringing on their rights. The Ombudsman indicated it was an infringement on their rights to not allow a relationship and the residents' cognitive impairment didn't matter as long as they had similar cognitive function. The SSD felt that if a resident was cognitively intact, and another resident was severely cognitively impaired, then that would be inappropriate. She felt the residents had the mental capacity to consent to sexual behaviors, but maybe not physically. They did not currently have an assessment for sexual behaviors. Resident F's clinical record was reviewed on 3/30/26 at 9:09 a.m. Diagnoses included major depressive disorder, single episode, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and Alzheimer's disease.A 2/17/26 annual MDS assessment indicated she had severe cognitive impairment and no behaviors were exhibited.Her medications included escitalopram oxalate (treats depression) 20 mg daily, buspirone (treats anxiety)10 mg three times daily, and memantine (treats dementia) 5 mg twice daily.A resolved care plan, created on 1/19/26 and resolved on 1/21/26, for inappropriate personal boundaries indicated she demonstrated behavior symptoms concerning inappropriate personal boundaries related to cognitive impairment secondary to Alzheimer's disease or dementia. These symptoms were manifested by: inappropriate touching (i.e., attempting to rub another person's back, reaching for a leg, shoulder rubbing or bump). Her goals included demonstrating respect for personal boundaries (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	during interaction with staff and peers and behaving with respect towards staff and peers (resolved 1/21/26). Interventions resolved on 1/21/26 included documenting, as appropriate, behavior symptoms such as disrespecting boundaries and assertively communicating to her that each person was expected to behave with dignity and respect, staff needed to be assertive when interacting with people who did not respect boundaries. It was important to: (A) establish clear boundaries, (B) reinforce the boundaries, do not waiver, do not show flexibility; enforce strict limits, (C) communicate how to set these limits with fellow staff members and (D) communicate how to handle this behavior to her who were approached by peers who did not respect boundaries, using phrases to clearly communicate what behavior was unacceptable and inappropriate, for example: Assertively tell him to respect your personal space & step back prior to speaking with you. and I am concerned about your well-being and I will help you function at your best. A current care plan, created on 1/21/26 and revised on 3/16/26, indicated she enjoyed companionship with a male peer within the facility. She enjoyed social engagement which may include affectionate acts such as hand holding or putting her arm around male peer. Her goals included exercising safe, respectful and appropriate practices, and her preference for social engagement/personal touch with male peer will be honored through next review. (revised 3/16/26) Her interventions included acknowledging the residents need for connection to make them feel valued (1/21/26), assessing her to determine her understanding of the nature of the act and her ability to refuse (1/21/26), encouraging appropriate touch such as hand holding, hugs, etc. If residents were being affectionate in a public setting, offering privacy to ensure dignity was maintained (1/21/26), encouraging participation in activities to reduce boredom which was often a reason for attention seeking (1/21/26), helping her maintain and preserve her dignity, integrity and confidentiality by discussing these matters in a room that afforded privacy (1/21/26), and offering psychosocial visits to ensure that she continued to be comfortable with her level of interaction with interactions with male peers (1/21/26).A nurses note, dated 8/27/25 at 12:34 p.m., indicated Resident F's Power of Attorney (POA) was notified regarding a male resident was friendly with Resident F. They spent a lot of time together and sought each other out for company. The POA was aware of the friendship and aware the male resident used his hands to talk with (i.e. patting hands and legs during conversations). Possible interventions were discussed with the POA to prevent possible progression for inappropriate behaviors, such as a stop sign or possible room move. The POA did not want Resident F moved and had concerns regarding a stop sign across the door of her room, as Resident F was unable to understand what the stop sign was for, fall risks, and it would cause agitation. The POA believed Resident F had adjusted to the facility and no longer indicated that she wanted the POA to talk her home. The POA did not want Resident F to be unhappy. An agreement was made related to an attempt at using stop sign but if Resident F did not adjust to or did not agree with stop sign then it needed to be removed. The POA indicated that her mother enjoyed conversations and interactions with the other resident and did not want to take that away from her.A nurses note, dated 1/21/26 at 9:52 a.m., indicated Resident F sought companionship with a male resident. The residents sought each other out and the relationship was mutual. The HCP was aware of the relationship and had no concerns. Her care plan was updated.Resident E's clinical record was reviewed on 3/28/26 at 9:32 a.m. Diagnoses included major depressive disorder, single episode and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.A 1/6/26 quarterly MDS assessment indicated she had moderate cognitive impairment and no behaviors were exhibited.Her medications included donepezil 10 mg daily. She had an order, dated 1/2/26, for behavior monitoring related to signs and symptoms of depression. Interventions included attempting to redirect, snack, offering fluid, activity for diversion, toileting, changing environment, pain assessment, offering a nap or rest period, and providing comfort measures.Her clinical record lacked monitoring and individualized interventions for intimate or sexual behaviors.A resolved care plan, created on 1/19/26 and resolved on 1/21/26, for inappropriate personal boundaries indicated she demonstrated behavior symptoms concerning inappropriate personal boundaries related to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	cognitive impairment secondary to Alzheimer's disease or dementia. These symptoms were manifested by: inappropriate touching (i.e., attempting to rub another person's back, reaching for a leg, shoulder rubbing or bump). Her goal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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. Based on record review and interview, the facility failed to ensure staff reported an allegation of abuse immediately to the Administrator, resulting in a delay in ensuring the allegation of abuse was reported to the State Agency within the required timeframe for 1 of 3 reportable incidents reviewed. (Resident B and Resident C) Findings include:Resident B's clinical record was reviewed on 3/26/26 at 9:44 a.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, single episode, and cognitive communication deficit.A 1/31/26, admission, Minimum Data Set (MDS) assessment indicated she had moderate cognitive impairment. A Situation, Background, Assessment, Recommendation (SBAR) summary, dated 3/23/26 at 2:56 p.m., indicated she was being sent to the emergency room for an evaluation of sexual assault per protocol related to staff observation of Resident B performing oral sex on a male resident. Staff intervened and the male resident was directed out of her room. Close supervision was maintained to ensure the male resident did not re-enter her room.Resident C's clinical record was reviewed on 3/26/26 at 11:39 a.m. Diagnoses included unspecified dementia, mild, with other behavioral disturbance, and delusional disorders.A 1/25/26, quarterly, MDS assessment indicated he had severe cognitive impairment.An SBAR summary, dated 3/23/26 at 3:04 p.m., indicated staff observed Resident C in another female resident's room receiving oral sex. Staff immediately asked him to leave the room; he was agitated with leaving but did comply. Staff monitored closely to ensure that he did not re-enter room or any other rooms. The provider was notified and recommended Resident B to be sent out for a psychiatric evaluation and treatment. Fifteen minutes checks and one on one supervision were completed until resident was sent for evaluation.During an interview on 3/26/26 at 1:51 p.m., Qualified Medication Aide (QMA) 7 indicated, on 3/22/26 between 7:00 p.m. and 8:00 p.m., she was passing medication and as she walked by Resident B's room, Resident B's roommate was seated in her wheelchair in the hall, and she saw half of Resident C's body in Resident B's room. Resident C was standing in front of Resident B with his walker between him and her, his pants were partially down exposing his buttocks. Resident B was seated in her recliner, leaning forward, and Resident C's right knee was propped up on the seat of his walker as he leaned forward towards Resident C. Resident B was performing oral sex on Resident C. QMA 7 asked Resident C to leave the room. He got mad, pulled up his pants, and left the room. She reported what she observed to the charge nurse, and they kept Resident C away from Resident B and other female residents. During an interview on 3/26/26 at 2:43 p.m. Registered Nurse (RN) 16 indicated QMA 7 reported to her that she observed Resident B performing oral sex on Resident C and told Resident C to leave the room. When QMA 7 reported the observation, RN 16 did not report it to anyone. She made a behavioral note. At the time, they had been told that it was okay for the residents to have a sexual relationship.During an interview on 3/27/26 at 10:20 a.m., the Administrator indicated she did not report the incident between Resident B and Resident C to the State Agency until the day after the incident. RN 16 reported the incident to the DON the following morning and then the DON reported the incident to the Administrator. A current facility policy, titled Abuse Prevention Program, provided by the Administrator on 3/30/26 at 10:36 a.m., indicated the following: .Abuse Reporting Policy .Procedure .the person(s) observing an incident of resident abuse or suspecting resident abuse must immediately report such incidents to the Charge Nurse, regardless of the time lapse since the incident occurred. The Charge Nurse will immediately report the incident to the Administrator .When an alleged or suspected case of abuse or neglect is reported to the Administrator, the Administrator, or person in charge of the facility, will notify the following persons or agencies of such incident immediately. State Licensing and Certification Agency (i.e. ISDH) This citation relates to Intake 2962257.410 Indiana Administrative Code (IAC)16.2-3.1-28(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview, and record review, the facility failed to monitor for and develop individualized interventions for cognitively impaired residents with sexually focused behavior expressions for 5 of 5 residents reviewed for behavioral services. (Residents B, C, D, E and F)Findings include:1.Resident B's clinical record was reviewed on 3/26/26 at 9:44 a.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, single episode, and cognitive communication deficit.A 1/31/26, admission, Minimum Data Set (MDS) assessment indicated she had moderate cognitive impairment and no behaviors were exhibited. Her medications included donepezil hydrochloride (treat dementia) 10 milligram (mg) daily.She had an order, dated 1/28/26, for behavior monitoring every shift related to signs and symptoms of depression, tearfulness, or self-isolation. Interventions included attempting redirection, snack, offering fluid, an activity for diversion, toileting, changing environment, pain assessment, offering a nap or rest period, and providing comfort measures. A social service note, dated 3/20/26 at 2:52 p.m., indicated her Power of Attorney (POA) and Emergency Contact was notified regarding Resident B seeking companionship with a male resident of the facility. She ate meals with the male resident and sat in lounge with him. Both representatives were in agreement with Resident B's actions. The facility would continue to monitor the relationship.A Situation, Background, Assessment, Recommendation (SBAR) summary, dated 3/23/26 at 2:56 p.m., indicated Resident B was being sent to the emergency room for an evaluation of sexual assault per protocol related to staff observation of Resident B performing oral sex on a male resident. The staff intervened and the male resident was directed out of her room. Close supervision was maintained to ensure the male resident did not re-enter her room.A nurse's note, dated 3/23/26 at 3:30 p.m., indicated that Resident B was spoken to regarding the incident. She would not/could not talk about incident. She reported that she was friends with the male resident and that he lost his wife recently and they were lonely. She denied the male resident ever touching her in unwanted and inappropriate manner. She adamantly denied the male resident touching her in an unwanted manner.A nurses note, dated 3/23/26 at 4:00 p.m., indicated at 2:00 p.m., staff reported observing Resident B in her room with a male resident, and Resident B performed oral sex on the male resident the previous evening. Staff asked the male resident to leave the room immediately; he was agitated but complied. Staff provided close monitoring to ensure the male resident did not re-enter the room. The Administrator, family, and physician were notified.A current care plan, revised 1/30/26, for impaired cognition/function or impaired thought process related to dementia with poor short and long-term memory. Interventions included cuing, reorientation, and supervision as needed (1/28/26), presenting one thought, idea, question or command at a time (1/28/26), and using task segmentation to support short term memory deficits, and break tasks into one step at a time (1/28/26).A current care plan, dated 2/2/26, indicated she required the use of a position change alarm related to poor safety awareness and impulsiveness with attempts to stand or self-transfer without assistance despite repeated direction, verbal cues and/or re-education.Resident B's clinical record lacked monitoring and individualized interventions for intimate or sexually focused behaviors prior to 3/20/26. 2.Resident C's clinical record was reviewed on 3/26/26 at 11:39 a.m. Diagnoses included unspecified dementia, mild, with other behavioral disturbance, and delusional disorders.A 1/25/26, quarterly, MDS assessment indicated he had severe cognitive impairment and no behaviors were exhibited. His current orders included risperidone (antipsychotic) 0.25 mg twice daily for delusional disorder and donepezil hydrochloride 5 mg daily. He had an order, dated 5/16/25, for behavior monitoring every shift related to delusions and paranoia, thoughts of his wife having an affair, self-picking of skin, insomnia, and difficulty sleeping. Interventions included attempting redirection, snack, offering fluid, an activity for diversion, toileting, changing environment, pain assessment, offering a nap or rest (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	period, and providing comfort measures. His medication orders indicated he received medroxyprogesterone acetate (synthetic female hormone) for hypersexuality. He had the following medication adjustments related to medroxyprogesterone acetate:On 8/1/25, he was started on 10 mg that was discontinued on 8/25/25. On 8/26/25, the medication was increased to 15 mg and was discontinued on 10/2/25. On 10/2/25, the medication was decreased to 10 mg and was discontinued on 2/5/26. On 2/6/26, the medication was decreased to 5 mg and was discontinued on 3/12/26. A resolved care plan, created on 11/21/25 and resolved on 1/21/26, for inappropriate personal boundaries. He demonstrated behavior symptoms concerning inappropriate personal boundaries due to: cognitive impairment secondary to Alzheimer's disease or dementia. The symptoms were manifested by inappropriate touching (i.e., attempting to rub another person's back, reaching for a leg, shoulder rubbing or bump). His goals included that he would refrain from making inappropriate remarks (resolved 1/21/26), he would demonstrate respect for personal boundaries during interaction with staff and peers (resolved 1/21/26), he would ask appropriate questions (resolved 1/21/26), he would behave with respect towards staff and peers (resolved 1/21/26), documenting, as appropriate, behavior symptoms such as disrespecting boundaries and assertively communicating to him that each person was expected to behave with dignity and respect (resolved 1/21/26), staff needed to be assertive when interacting with people who did not respect boundaries. It was important to: (A) establish clear boundaries, (B) reinforce the boundaries, do not waiver, do not show flexibility; enforce strict limits, (C) communicate how to set these limits with fellow staff members and (D) communicate how to handle this behavior to him, who were approached by peers, who did not respect boundaries (resolved 1/21/26), using phrases to clearly communicate what behavior was unacceptable and inappropriate, for example: Assertively tell him to respect your personal space and step back prior to speaking with you and I am concerned about your wellbeing and I will help you function at your best. (resolved 1/21/26)A current care plan, dated 1/21/26, indicated he had a companionship with some female peers within the facility. He enjoyed social engagement which may include affectionate acts such as hand holding or putting his arm around female peers. His goal was that he would exercise safe, respectful and appropriate practices, and his preference for social engagement/personal touch with female peers would be honored through next review. (1/21/26) Interventions included acknowledging the residents' need for connection to make them feel valued (1/21/26), assessing him to determine his understanding of the nature of the act and his ability to refuse (1/21/26), encouraging appropriate touch such as hand holding, hugs, etc. If residents were being affectionate in a public setting, offering privacy to ensure dignity was maintained (1/21/26), encouraging participation in activities to reduce boredom which was often a reason for attention seeking (1/21/26), helping him maintain and preserve his dignity, integrity and confidentiality by discussing these matters in a room that affords privacy (1/21/26), offering psychosocial visits to ensure that he continued to be comfortable with his level of interactions with female peers (1/21/26).Resident C's clinical record lacked monitoring and individualized interventions for intimate or sexual behaviors. A nurses note, dated 7/31/25 at 10:50 a.m., indicated Resident C was noted to have increased friendliness towards female residents (patting arms and hand holding). Education and re-enforcement on appropriate behaviors was provided to Resident C. The Nurse Practitioner (NP) recommended starting medroxyprogesterone. The physician and the resident's family were in agreement. A social service note, dated 8/7/25 at 9:56 a.m., indicated that it was reported Resident C was sitting on his rollator walker in front of a female resident talking in a female resident's room. He indicated that they were talking, then got up, and indicated that it was time to go. The female resident was asked if she was ok and comfortable. The female resident indicated that they were just talking. A nurses note, dated 8/25/25 at 12:46 p.m., indicated he was visiting in another resident's room. When asked to leave the room, he became agitated and cursed at staff. He remained friendly. He frequently used his hands when talking with staff and residents. He touched hands and rubbed arms, etc. He indicated that he always used his hands to talk and was able to get his point across when he used his (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hands and felt it was respectful. He was unable to understand that he needed to not touch other residents, even in a friendly innocent manner, and not all residents were able to make decisions for themselves. No improvement was noted since starting medroxyprogesterone. New orders were received to increase medroxyprogesterone to 15 mg daily. A nurses note, dated 10/2/25 at 10:37 a.m. indicated Interdisciplinary (IDT) behavior meeting recommended to decrease his medroxyprogesterone. A nurses note, dated 1/21/26 at 9:43 a.m., indicated he sought companionship with another female resident. The residents sought each other out and the relationship was mutual. His care plan was updated.A care plan meeting note, dated 1/26/26 at 10:15 a.m., indicated that he was alert to self and place. He sought companionship with female residents. He enjoyed spending time talking and holding hands. His family was aware and in agreement. He was care planned appropriately.An IDT note, dated 2/3/26 at 7:51 p.m., indicated he continued with usual affect, daily routine, and seeking out female companionship. He had no signs or symptoms of delusions, irritability, or social withdrawal. He was due for a gradual dose reduction (GDR) of medroxyprogesterone. IDT recommended decreasing to 5 mg daily.An IDT note, dated 3/11/26 at 12:51p.m., indicated pharmacy recommended discontinuing medroxyprogesterone. The physician and IDT were in agreement to discontinue. He continued with usual routine but decreased interaction with other female residents. The IDT would continue to monitor.A social service note, dated 3/18/26 at 12:31p.m., indicated he was observed holding hands with a female resident in the central lounge after breakfast, then observed talking with different female resident in main dining room after lunch.A social service note, dated 3/19/26 at 8:57 a.m., indicated he had increased aggravation when staff attempted to redirect or orientate him. Yesterday afternoon, he was visiting with another female resident in the main dining room and began to get angry with staff because they would not leave them alone. The female resident required assistance and could walk by herself. A social service note, dated 3/19/26 at 9:33 a.m., indicated the DON felt that Resident C was failing his GDR of medroxyprogesterone due to increased interactions with female residents.A behavior note, dated 3/22/26 at 3:20 p.m., indicated that he had increased agitation and interactions with female peers. He was asked to visit females in the public lounge and not in the room. He became angry and said, I'll just fix this and angerly walked away cursing at staff. Interventions were effective for a short moment. He had a short-term memory problem.A behavior note, dated 3/22/26 at 8:11 p.m., indicated he became very agitated with staff upon redirection from female residents. He had an (unspecified) inappropriate behavior with a confused female resident and he was redirected from the room.A nurses note, dated 3/23/26 at 1:09 p.m., the Psychiatric NP was updated related to increased interactions with a female resident since medroxyprogesterone was discontinued. The medroxyprogesterone seemed to inhibit his desires, now that the medication was stopped, desires seemed to be escalated. New orders were received to restart at previous dose of medroxyprogesterone as the GDR failed.A SBAR summary, dated 3/23/26 at 3:04 p.m., indicated staff observed Resident C in another female resident's room receiving oral sex. The staff immediately asked him to leave the room; he was agitated with leaving but did comply. Staff monitored closely to ensure that he did not re-enter the room or any other rooms. The provider was notified and recommended Resident B to be sent for a psychiatric evaluation and treatment. Fifteen minute checks and one on one supervision were initiated until he could be sent for an evaluation.3. Resident D's clinical record was reviewed on 3/27/26 at 9:11 a.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A 1/25/26, quarterly, MDS assessment indicated she had severe cognitive impairment and no behaviors were exhibited. Her medications included escitalopram oxalate (treat depression) 20 mg daily.She had an order, dated 10/15/25, for behavior monitoring related to tearfulness, being withdrawn, anxiety, restlessness, and agitation. Interventions included attempting to redirect, snack, offering fluid, activity for diversion, toileting, changing environment, pain assessment, offering a nap or rest period, and providing comfort measures. A resolved care plan, created on 1/19/26 and resolved on 1/21/26, for inappropriate personal boundaries indicated she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	demonstrated behavior symptoms concerning inappropriate personal boundaries related to cognitive impairment secondary to Alzheimer's disease or dementia. These symptoms were manifested by: inappropriate touching (i.e., attempting to rub another person's back, reaching for a leg, shoulder rubbing or bump). Her goals included demonstrating respect for personal boundaries during interactions with staff and peers and behaving with respect towards staff and peers (resolved 1/21/26). Interventions resolved on 1/21/26 included documenting, as appropriate, behavior symptoms such as disrespecting boundaries and assertively communicating to her that each person was expected to behave with dignity and respect, staff needed to be assertive when interacting with people who did not respect boundaries. It is important to: (A) establish clear boundaries, (B) reinforce the boundaries, do not waiver, do not show flexibility; enforce strict limits, (C) communicate how to set these limits with fellow staff members and (D) communicate how to handle this behavior to her, who were approached by peers and who did not respect boundaries, using phrases to clearly communicate what behavior was unacceptable and inappropriate, for example: Assertively tell him to respect your personal space and step back prior to speaking with you and I am concerned about your well-being and I will help you function at your best. (1/21/26)A care plan, created on 1/21/26 and revised on 3/16/26, indicated she enjoyed companionship with a male peer within the facility. She enjoyed social engagement which may include affectionate acts such as hand holding or putting her arm around male peer. Her goals included exercising safe, respectful and appropriate practices, and her preference for social engagement/personal touch with male peer will be honored through next review (1/21/26). Her interventions included acknowledging the resident's need for connection to make them feel valued (1/21/26), assessing her to determine her understanding of the nature of the act and her ability to refuse (1/21/26), encouraging appropriate touch such as hand holding, hugs, etc. If residents were being affectionate in a public setting, offering privacy to ensure dignity was maintained (1/21/26), encouraging participation in activities to reduce boredom which was often a reason for attention seeking (1/21/26), helping her maintain and preserve her dignity, integrity and confidentiality by discussing these matters in a room that offers privacy (1/21/26), and offering psychosocial visits to ensure that she continued to be comfortable with her level of interactions with male peers (1/21/26). A nurses note, dated 1/21/26 at 9:42 a.m., indicated she sought companionship with a male resident. They sought each other out and the relationship was mutual. The provider was aware of the relationship and had no concerns. Her care plan was updated.Her clinical record lacked monitoring and individualized interventions for intimate or sexual behaviors. 4. Resident E's clinical record was reviewed on 3/28/26 at 9:32 a.m. Diagnoses included major depressive disorder, single episode and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A 1/6/26, quarterly, MDS assessment indicated she had moderate cognitive impairment and no behaviors were exhibited. Her medications included donepezil 10 mg daily. She had an order, dated 1/2/26, for behavior monitoring related to signs and symptoms of depression. Interventions included attempting to redirect, snack, offering fluid, activity for diversion, toileting, changing environment, pain assessment, offering a nap or rest period, and providing comfort measures. A resolved care plan, created on 1/19/26 and resolved on 1/21/26, for inappropriate personal boundaries indicated she demonstrated behavior symptoms concerning inappropriate personal boundaries related to cognitive impairment secondary to Alzheimer's disease or dementia. These symptoms were manifested by: inappropriate touching (i.e., attempting to rub another person's back, reaching for a leg, shoulder rubbing or bump). Her goals included demonstrating respect for personal boundaries during interaction with staff and peers and behaving with respect towards staff and peers (resolved 1/21/26). Interventions resolved on 1/21/26 included documenting, as appropriate, behavior symptoms such as disrespecting boundaries and assertively communicating to her that each person was expected to behave with dignity and respect, staff needed to be assertive when interacting with people who did not respect boundaries. It was important to: (A) establish clear boundaries, (B) reinforce the boundaries, do not waiver, do not show flexibility; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	enforce strict limits, (C) communicate how to set these limits with fellow staff members and (D) communicate how to handle this behavior to her who were approached by peers and who did not respect boundaries, using phrases to clearly communicate what behavior was unacceptable and inappropriate, for example: Assertively tell him to respect your personal space and step back prior to speaking with you. and I am concerned about your well-being and I will help you function at your best. A current, 1/21/26, care plan indicated she enjoyed companionship with a male peer within the facility. She enjoyed social engagement which may include affectionate acts such as hand holding or putting her arm around male peer. Her goals included exercise safe, respectful and appropriate practices, and her preference for social engagement/personal touch with the male peer would be honored through next review (1/21/26). Her interventions included acknowledging the resident's need for connection to make them feel valued (1/21/26), assessing her to determine her understanding of the nature of the act and her ability to refuse (1/21/26), encouraging appropriate touch such as hand holding, hugs, etc. If residents were being affectionate in a public setting, offering privacy to ensure dignity was maintained (1/21/26), encouraging participation in activities to reduce boredom which was often a reason for attention seeking (1/21/26), helping her maintain and preserve her dignity, integrity and confidentiality by discussing these matters in a room that afforded privacy (1/21/26), and offering psychosocial visits to ensure that she continued to be comfortable with her level of interaction with interactions with male peers (1/21/26).A nurses note, dated 1/21/26 at 10:52 a.m., indicated she sought companionship with a male resident. The residents sought each other out and the relationship was mutual. The HCP was aware of the relationship and had no concerns. Her care plan was updated.A behavior note, dated 3/11/26 at 1:22 a.m., indicated she talked very inappropriately to staff during evening meal. She called one of the Certified Nurse Aides (CNA) over and loudly made comments about the CNA's breasts. The CNA attempted to redirect the resident's comments, but she continued to loudly talk about the CNA's breasts in the dining room. When returning to her room, the CNA was assisting a resident across hall. Resident E indicated that she was ready to go to bed. The CNA explained to Resident E that she was currently assisting another resident to the bathroom, cleaning him up and when she was finished, she would help her. Resident E indicated to make sure the CNA kissed him down there and pointed at her peri area then indicated he would really like that. An attempt was made for Resident E to be verbally redirected and educated that talking like that was not appropriate. When staff assisted Resident E to bed, she asked the CNA if she would kiss her down there and pointed at her peri area. The CNA indicated for her to stop talking like that and that it was not appropriate. Resident E then indicated that she would get Resident C to do it and he would do it. The CNA attempted to redirect Resident E without success. A behavior note, dated 3/11/26 at 4:00 a.m., indicated she was being verbally inappropriate when a CNA entered the room to assist Resident E's roommate with care. Resident E asked the CNA to get in bed with her and give her some love and she would give the CNA some good love. Verbal redirection was given that her comments were inappropriate. Resident E's clinical record lacked monitoring and individualized interventions for intimate or sexual behaviors. 5. Resident F's clinical record was reviewed on 3/30/26 at 9:09 a.m. Diagnoses included major depressive disorder, single episode, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and Alzheimer's disease. A 2/17/26, annual, MDS assessment indicated she had severe cognitive impairment and no behaviors were exhibited. Her medications included escitalopram oxalate (treats depression) 20 mg daily, buspirone (treats anxiety)10 mg three times daily, and memantine (treats dementia) 5 mg twice daily.She had an order, dated 1/7/26, for behavior monitoring related to signs and symptoms of depression (tearfulness, self-isolation, anxiety, picking at skin and repetitive questions and statements. Interventions included attempting to redirect, snack, offering fluid, activity for diversion, toileting, changing environment, pain assessment, offering a nap or rest period, and providing comfort measures. A resolved care plan, created on 1/19/26 and resolved on 1/21/26, for inappropriate personal boundaries indicated she demonstrated behavior (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	symptoms concerning inappropriate personal boundaries related to cognitive impairment secondary to Alzheimer's disease or dementia. These symptoms were manifested by: inappropriate touching (i.e., attempting to rub another person's back, reaching for a leg, shoulder rubbing or bump). Her goals included demonstrating respect for personal boundaries during interaction with staff and peers and behaving with respect towards staff and peers (resolved 1/21/26). Interventions resolved on 1/21/26 included documenting, as appropriate, behavior symptoms such as disrespecting boundaries and assertively communicating to her that each person was expected to behave with dignity and respect, staff needed to be assertive when interacting with people who did not respect boundaries. It was important to: (A) establish clear boundaries, (B) reinforce the boundaries, do not waiver, do not show flexibility; enforce strict limits, (C) communicate how to set these limits with fellow staff members and (D) communicate how to handle this behavior to her who were approached by peers who did not respect boundaries, using phrases to clearly communicate what behavior was unacceptable and inappropriate, for example: Assertively tell him to respect your personal space & step back prior to speaking with you. and I am concerned about your well-being and I will help you function at your best. A current care plan, created on 1/21/26 and revised on 3/16/26, indicated she enjoyed companionship with a male peer within the facility. She enjoyed social engagement which may include affectionate acts such as hand holding or putting her arm around male peer. Her goals included exercising safe, respectful and appropriate practices, and her preference for social engagement/personal touch with male peer will be honored through next review. (revised 3/16/26) Her interventions included acknowledging the residents need for connection to make them feel valued (1/21/26), assessing her to determine her understanding of the nature of the act and her ability to refuse (1/21/26), encouraging appropriate touch such as hand holding, hugs, etc. If residents were being affectionate in a public setting, offering privacy to ensure dignity was maintained (1/21/26), encouraging participation in activities to reduce boredom which was often a reason for attention seeking (1/21/26), helping her maintain and preserve her dignity, integrity and confidentiality by discussing these matters in a room that afforded privacy (1/21/26), and offering psychosocial visits to ensure that she continued to be comfortable with her level of interaction with interactions with male peers (1/21/26).A nurses note, dated 8/27/25 at 12:34 p.m. indicated Resident F's Power of Attorney (POA) was notified regarding a male resident was friendly with Resident F. They spent a lot of time together and sought each other out for company. The POA was aware of the friendship and aware the male resident used his hands to talk with (i.e. patting hands and legs during conversations). Possible interventions were discussed with the POA to prevent possible progression for inappropriate behaviors such as a stop sign or possible room move. The POA did not want Resident F moved and had concerns regarding a stop sign across the door of her room as Resident F was unable to understand what the stop sign was for, fall risks, and it would cause agitation. The POA believed Resident F had adjusted to the facility and no longer indicated that she wanted the POA to talk her home. The POA did not want Resident F to be unhappy. An agreement was made related to an attempt at the stop sign but if Resident F did not adjust to or did not agree with stop sign then it needed to be removed. The POA indicated that her mother enjoyed conversations and interactions with the other resident and did not want to take that away from her.A nurses note, dated 1/21/26 at 9:52 a.m. indicated she sought companionship with a male resident. The residents sought each other out and the relationship was mutual. The HCP was aware of the relationship and had no concerns. Her care plan was updated.Resident F's clinical record lacked monitoring and individualized interventions for intimate or sexual behaviors. During an interview on 3/30/26 at 9:43 a.m., the Social Service Director (SSD) indicated Resident C was social with everyone, male or female. He normally sat at the dining room drinking coffee and females gravitated toward him. Resident F walked around with him at times, during her peak confusion he would get slightly annoyed with her, she would ask Where do you want to go? and What you want to do? Resident D sat in the lounge, and Resident C stopped and talk to her, that was how their friendship developed. Resident E played Bingo with Resident F and they would (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155571	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Dunkirk Skilled Nursing Facility, The	11563 W 300 S Dunkirk, IN 47336

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	argue who was going to sit with Resident C. Resident B sat at the dining table for meals and Resident B and Resident C started talking. The facility resolved care plans after speaking with the Ombudsman to determine whether the behaviors were inappropriate or the residents' rights. Resident C's hypersexuality increased with the number of females that he was making friends with. When Resident C was redirected, he was aggravated and asked why he could not talk to the female resident. He held hands and patted Resident E's and Resident D's legs. Resident C held hands with Resident B. The staff completed behavior tools and then she would put a note in Point Click Care (PCC). The behavior sheets were located in a behavior tool folder at each nurse's station. The CNAs were unable to read the care plans in PCC but could see the behaviors on the behavior sheets. Resident C was on medroxyprogesterone, and psychotropic behavior monitoring would be located on the Medication Administration Record (MAR). The DON or ADON added the psychotropic monitoring to the MARs. The behaviors were reviewed monthly. The behaviors were a fine line between being appropriate or infringing on their rights. The Ombudsman indicated it was an infringement on their rights, there BIMS score did not matter and as long as their BIMS score were similar. The SSD felt that if a resident had a BIMS of 15 (intact cognition) and another resident had a BIMS score of 3 (severe cognitive impairment) that would be inappropriate. She felt the residents had the mental capacity to consent to sexual behaviors but maybe not physically. They did not currently have an assessment for sexual behaviors. Behavior sheets were reviewed on 3/30/26 at 10:27 a.m. and indicated the following:Resident B had no behaviors that were monitored.Resident C had behaviors related to irritability with other residents, increased episodes of anxiety which included indicating that he missed a flight, had an appointment which he was late for, and he searched for his family member. Interventions included providing reassurance, calling family, and offering him a cup of coffee or ice cream. Resident D had no behaviors that were monitored. Resident E had no behaviors that were monitored. Resident F had behaviors related to increased anxiousness, asking where her daughter was and what she should do, and pacing. Interventions included calling her daughter, providing one on one, assessing Activities of Daily Living (ADL) needs and talking about where she grew up. A current facility policy, titled Guidelines for Behavior Management Meetings Psychotropic Medication (Behavior Management Meetings), provided by HFA 2 on 3/30/26 at 10:36 a.m. indicated the following: Policy .These meetings are held monthly or more often as needed. The purpose is to review residents who have behaviors and who are being monitored for these behaviors. Further, to discuss and review residents who have newly developed behaviors to ensure that all appropriate interventions are in place to manage the behaviors with non-pharmacological interventions or the least dosage of psychoactive med(s) possible to promote and maintain the highest degree of psychosocial well-being and quality of life . Roles-Responsibilities .Nursing .2) Monitors for presence of target behaviors on a daily basis and documenting same . 5) Assist in developing behavior care plans .Social Services 1) Maintains a list of residents with behaviors .5) Assists in behavior care plans This citation relates to Intake 2962257.410 Indiana Administrative Code (IAC) 16.2-3.1-43(a)(2)