

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Waters of Greencastle, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 Hospital Dr Greencastle, IN 46135	
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to supervise and ensure the safety of a resident with dementia residing on the locked dementia unit when an exit glass door and an outside courtyard gate were left open by a contractor and the resident eloped from the facility and fell into a ditch for 1 of 3 residents reviewed for accidents (Resident B). The immediate jeopardy began on 6/2/26 at 1:58 p.m., when Resident B was observed via video footage exiting the gate from the locked unit courtyard. She continued across the parking lot into a grassy field. She walked at a rapid pace, carrying a blanket in front of her. She walked approximately 100 yards and veered towards the road and was observed falling on her face in a ditch. She was observed trying to get up and falling again. She was on the ground for 13 minutes before a hospital staff member approached her, but she was unable to stand. He indicated she was about 2 1/2 to 3 feet from the road between the facility and the hospital. Facility staff were seen arriving to assist the resident after the hospital staff member left to get assistance. The Director of Nursing, Regional Nurse Consultant, and Regional Director of Operations were notified of the Immediate Jeopardy on 6/16/26 at 3:02 p.m. The immediate jeopardy was removed on 6/16/26, but the 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: Observation of a surveillance video, provided by an acute care hospital on 6/15/26 at 10:55 a.m., included the following: Resident B exited the facility's locked courtyard gate at 1:58 p.m. on 6/2/26, and walked across the facility's parking lot towards a grassy area. She continued to walk across a rolling, grassy area at a rapid pace and was carrying a blanket. After going approximately 100 yards, the resident turned toward the road and fell at 2:00 p.m., face first, into a ditch. She attempted to get up, was unable to do so, and again fell forward. The resident sat up, appearing close to the edge of the road. Approximately six vehicles were seen driving down the road during this time. A beige SUV stopped on the opposite side of the road and a hospital employee can be viewed reaching Resident B at 2:11 p.m. At 2:14 p.m., a silver SUV arrived and stopped on the same side as the resident. At 2:17 p.m., other staff members crossed the grassy area and arrived. Resident B was placed in the silver SUV and at 2:20 p.m., and the silver SUV pulled away. According to the website Accuweather at https://www.accuweather.com/en/us/greencastle/46135/june-weather/332953, accessed on 6/18/26 at 6:58 a.m., the temperature in the afternoon on 6/2/26 was 78 degrees Fahrenheit (F). A clinical record review for Resident B was completed on 6/15/26 at 12:49 p.m. Diagnoses included vascular dementia (a decline in thinking and memory skills caused by conditions that block or reduce blood flow to the brain) and anxiety disorder (chronic, exaggerated worry about everyday events that is difficult to control). The resident admitted to the locked Memory Care unit on 6/1/26. An admission Wandering Risk Scale, completed 6/1/26 at 4:35 p.m., indicated the resident was at moderate risk for wandering. The resident was ambulatory and had a medical diagnosis of dementia. An admission Baseline Care Plan Assessment, completed on 6/1/26 at 4:38 p.m., indicated the resident was a risk for elopement. Interventions included to monitor doors when staff and visitors come and go, and if wandering in potentially unsafe areas, to redirect to safer area. An Activity admission Evaluation, (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dated 6/1/26 at 2:16 p.m., indicated Resident B had poor short- and long-term memory, and used nonsensical/slurred speech. She was ambulatory. A nursing progress note, dated 6/2/26 at 3:00 p.m., included the Administrator had spoken to Resident B's spouse making him aware that the resident had followed a contractor out of the memory care courtyard door, and that she had stumbled in the grass before staff could reach her. She had a small scratch on her nose from her glasses. Facility staff brought her back into the building and she was resting. During an interview on 6/15/26 at 10:50 a.m., an employee of an acute care hospital indicated he received a call at 2:10 p.m. from someone parked in the hospital parking lot. The caller told him there was a lady on the side of the road across the street from the hospital who appeared to be unable to get up. The hospital employee went out to the parking lot and walked toward the road and could see an SUV pull up and stop. Upon going across the street, he saw Resident B laying on her side by the road. When he spoke to her she looked at him but did not respond. The man sitting in the SUV indicated to him that he had called someone for help. The employee then returned to the hospital to get help, and when he returned, others were observed with the lady and waved him away, indicating they were helping her. During an interview on 6/15/26 at 1:37 p.m., the Administrator indicated Resident B had exited the building through the glass, double doors at the end of the hallway into the courtyard. The outside courtyard gate had been open so the contractor could go back and forth to an outside vehicle with supplies to fix the air conditioning unit. The glass, double doors must not have latched when the contractor had last exited the building. Resident B walked across the parking lot into the grassy area and fell. During a telephone interview on 6/16/26 at 11:15 a.m., Dietary Aide 9 indicated he was seated in his car during his lunch break and noticed the resident lying on the ground. He immediately called the facility and reported that the resident was on the ground. During a telephone interview on 6/16/26 at 12:59 p.m., CNA 4 indicated she had gotten off work and was driving towards the main entrance of the hospital parking lot. She saw a dietary aide parked on the road and Resident B lying in the ditch across the street from where he was parked. She got out of her car and went to the resident. The employee in the other car had indicated he called the facility to report the resident lying next to the road. She remained with the resident until other staff arrived. She had fallen in a small ditch by the road about halfway between the facility and the hospital in a grassy area, about 100 yards from the facility. She was approximately 2 1/2 to 3 feet from the edge of the road. When she approached Resident B, she was lying on her side, curled up with a blanket, holding her glasses in her hand. She had a scratch on her nose. Other facility staff arrived and they assessed Resident B, then helped her get on her feet. She walked with assistance to CNA 4's car and was helped into the passenger seat. CNA 4 then drove her to the front entrance of the building where other staff assisted her into the building. She appeared to be walking without any visible issues. During an interview on 6/17/26 at 10:22 a.m., CNA 6 indicated she was working on the memory care unit on 6/2/26, and saw Resident B walking up and down the hallways holding a blanket around 1:30 p.m. CNA 6 had clocked out and was talking to another resident's family member in front of the facility outside the entrance doors. The Administrator, DON and QMA/Scheduler ran out of the front doors of the facility. CNA 6 and CNA 8 followed them, thinking someone needed help. They walked across the grassy area to the side of the building, to about 100 yards, and she observed Resident B on the ground with another CNA. She seemed alert and awake and did not appear to be crying. She had a mark on her nose and was holding a blanket tightly. They stood her up and assisted her to CNA 4's car that was parked on the road. She only had socks on her feet. CNA 6 felt at that point, Resident B appeared confused and tearful. CNA 6 went back to the front entrance and when Resident B arrived, she gave her a hug and she was taken back to the unit. CNA 6 indicated the resident's gait was at her normal and she lacked any appearance of being in pain. During an interview on 6/17/26 at 10:57 a.m., CNA 8 indicated she went out to the grassy field when other staff were observed headed that way. She observed Resident B holding a blanket and sitting on the ground. She had a little blood on her nose. She observed the resident when she was walking to the car and again when she was walking into the facility and had not noticed the resident having any (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	discomfort or change in her usual gait. A current facility policy, undated, titled, Policy and Procedure Regarding Missing Residents and Elopement, provided by the Regional Nurse Consultant on 6/17/26 at 12:48 p.m., included the following: .Prevention of Missing Residents and Elopements 1. Environmental. At no time will any door alarm or personal safety device be deactivated without continual direct visit supervision of the exit(s). The immediate jeopardy that began on 6/2/26 was removed on 6/16/26 when the facility implemented a systemic plan that included the following actions: conducted a facility wide audit of all resident risk assessments for elopement risk and update of elopement binders. All resident care plans were reviewed. Alarms for all locations were checked daily and logged beginning June 2026 for magnetic locks, wandering system alarms, door station alarms, and remote alarms. Skin assessments were completed for all memory care residents. Education was provided to all nursing staff on elopement policy and procedures. Pre and Post tests completed for all staff with infrequently scheduled employees flagged for education and testing prior to working in the facility. The 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 because of the facility's need for continued monitoring. This citation relates to Intakes 3041631 and 3042609. 410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(2)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility Administrator and Director of Nursing (DON) failed to communicate accurate information, complete accurate documentation, and pressured facility staff to provide false statements for an elopement from the memory care unit for 1 of 5 residents reviewed for accidents (Resident B). This deficiency had the potential to affect 68 of 68 residents residing at the facility who were overseen by the Administrator and DON. Findings include: During an interview on 6/15/26 at 12:29 p.m., Resident B's spouse indicated he had been caring for his wife at home and was very sad he had to make the decision to place her in a safer environment due to her dementia. His wife was admitted to the facility on [DATE]. He received a call from the Administrator around 3:00 p.m. on 6/2/26. She indicated Resident B had a little incident when she followed a contractor out of the memory care doors and had fallen in a grassy area. She indicated she was okay. Before going into a care plan meeting on 6/8/26, the Hospice Nurse told him Resident B had fallen outside the courtyard gates and across the parking lot in a grassy area. During the meeting, he was not told she was beyond the locked gates when she fell. During the meeting, he asked to see the incident report for the fall outside. The Administrator indicated she would let him see the nurses' notes. He had not heard anything further and had stopped trying to get information from her. After the meeting, he went over to the acute care hospital across the road from the facility because he felt like something was not right. He asked to speak to someone about an incident that had occurred on 6/2/26. A hospital employee asked if he was referring to information about the woman who fell. The hospital employee showed him where she was found, about 100 yards from the facility. The employee believed she was outside for at least 15 minutes before being placed in a vehicle and taken back to the facility. He was not allowed to see the video footage from the hospital surveillance cameras. The administrator had stopped contacting him or responding to his questions. He will be transferring her to another facility this afternoon (6/15/26). A clinical record review for Resident B was completed on 6/15/26 at 12:49 p.m. Diagnoses included vascular dementia (a decline in thinking and memory skills caused by conditions that block or reduce blood flow to the brain) and anxiety disorder (chronic, exaggerated worry about everyday events that is difficult to control). The resident admitted to the locked Memory Care unit on 6/1/26. An admission Wandering Risk Scale, completed 6/1/26 at 4:35 p.m., indicated the resident was at moderate risk for wandering. The resident was ambulatory and had a medical diagnosis of dementia. An admission Baseline Care Plan Assessment, completed on 6/1/26 at 4:38 p.m., indicated the resident was a risk for elopement. Interventions included to monitor doors when staff and visitors come and go, and if wandering in potentially unsafe areas, to redirect to safer area. An Activity admission Evaluation, dated 6/1/26 at 2:16 p.m., indicated Resident B had poor short- and long-term memory, and used nonsensical/slurred speech. She was ambulatory. A nursing progress note, dated 6/2/26 at 3:00 p.m., included the Administrator had spoken to Resident B's spouse making him aware that the resident had followed a contractor out of the memory care courtyard door, and that she had stumbled in the grass before staff could reach her. She had a small scratch on her nose from her glasses. Facility staff brought her back into the building and she was resting. A Care Plan Meeting Progress note, dated 6/8/26, included that Resident B's spouse had asked for details about Resident B's second fall. The Administrator indicated that she had informed him previously and that Resident B had followed a facility contractor outside of the building. The facility staff had eyes on her the entire time and had her back into the building within a few minutes. During an interview on 6/15/26 at 1:37 p.m., the Administrator indicated the reason Resident B's elopement was not reported to the State Agency was because the resident had not left the property, and there had been a staff person who had eyes on her the entire time. She had gotten out of the locked glass, double doors due to them not being completely closed after maintenance had exited. The outside gate had been open so the contractor could go back and forth to an outside HVAC unit and his (continued on next page)		

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The Administrator indicated the resident was found lying on the grass approximately 25 yards from the courtyard gate. The Administrator indicated when the dietary aide called the facility, they immediately went to the resident and brought her back into the facility in an employee's vehicle to the main entrance. During an interview on 6/16/26 at 9:45 a.m., the DON indicated she was sitting in the Administrator's office on 6/2/26 when they received a call that Resident B had been found outside at 2:10 p.m. They immediately went outside to where the resident was lying in the grass and found CNA 4 sitting with Resident B in the grassy area beyond the parking lot. She had a small scratch on her nose and was holding her glasses in her left hand. CNA 4's vehicle was parked on the road by the entrance. The resident was helped to her feet and assisted into the CNA's vehicle and taken to the front entrance of the facility. She walked into the facility without any distress noted. During an observation on 6/16/26 at 10:00 a.m., the DON indicated the resident had been found in the grassy area across the parking lot. The area she indicated was a little further out and closer to the road than previously observed with the Administrator. She indicated where CNA 4's vehicle was parked and that the staff had assisted the resident to the car. The path to the car was observed to have a ditch prior to reaching the street. The DON indicated that the resident had no problem walking through the ditch to get to the vehicle. The resident was then driven to the facility entrance and walked back to the memory care unit for further assessment. During an interview on 6/16/26 at 9:42 a.m. CNA 8 indicated she had gone out to her car sometime after 2:00 p.m. on 6/2/26. She had noticed people in the grass just off to the side of the building and began to move that way. The Administrator waved her off and said that no further help was needed. That was all she could remember. She had observed Resident B wandering up and down the halls carrying a blanket around 1:30 p.m. in the memory care unit prior to her elopement. During an interview on 6/16/26 at 12:41 p.m., Dietary Aide 9 indicated he was sitting in his car after 2:00 p.m. on 6/2/26. He saw the courtyard gate open and Resident B walked out. He thought at first it was a family member because she walked toward the cars. He watched her cross the parking lot into the grassy area. He drove his car towards the exit and tried to talk to her. She lowered herself to one knee and leaned down. Another employee came out of the facility and drove to the resident in her vehicle. She was only there for about a minute and a half before staff arrived and took her back into the facility. At no time was she out of his sight. Observation of a surveillance video, provided by an acute care hospital on 6/15/26 at 10:55 a.m., included the following: Resident B exited the facility's locked courtyard gate at 1:58 p.m. on 6/2/26, and walked across the facility's parking lot towards a grassy area. She continued to walk across a rolling, grassy area at a rapid pace and was carrying a blanket. After going approximately 100 yards, the resident turned toward the road and fell at 2:00 p.m., face first, into a ditch. She attempted to get up, was unable to do so, and again fell forward. The resident sat up, appearing close to the edge of the road. Approximately six vehicles were seen driving down the road during this time. A beige SUV stopped on the opposite side of the road and a hospital employee can be viewed reaching Resident B at 2:11 p.m. At 2:14 p.m., a silver SUV arrived and stopped on the same side as the resident. At 2:17 p.m., other staff members crossed the grassy area and arrived. Resident B was placed in the silver SUV and at 2:20 p.m., and the silver SUV pulled away. During a telephone interview on 6/16/26 at 10:22 p.m., the Hospice Nurse indicated the Administrator had called her on 6/4/26 and apologized for not having contacted her regarding the (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	fall outside of the facility on 6/2/26. The Administrator told her that Resident B had followed a contractor out to the courtyard and fell in the grass. Then on 6/7/26, a facility CNA approached her and said they were not being honest about the resident's fall outside the building. During the care plan meeting, Resident B's spouse asked the Administrator where she had been found when she got out of the building. The Administrator said she tumbled in the grass in the courtyard, then clarified it was the grassy area just outside the courtyard, then clarified again, that it was in the grassy area across the parking lot. At the end of the care plan meeting, the Hospice Executive Director, who was attending via telephone, asked the Administrator if she had reported the elopement to the State Agency. The Administrator indicated it was not reported because, according to policy, it was not an elopement if eyes were on the resident at all times. The Hospice Executive Director indicated she would be submitting a report regarding Resident B's elopement. The Administrator became very upset and began to yell at the phone and at the Hospice Nurse, This is the last time [Hospice Provider] is going to f--- me over! The Hospice Nurse indicated she had been advocating for her resident and her spouse, because the truth was not being shared. During a telephone interview on 6/16/26 at 12:59 p.m., CNA 4 indicated she had gotten off work and when she turned out of the parking lot, she observed another employee's vehicle parked on the side of the road. She parked her car facing the other direction and got out of her car. Resident B was lying on the grass halfway between the hospital and the facility. She was 2 to 3 feet off the road, lying on her side curled up with a blanket and holding her glasses. She had left the facility a little after 2:10 to 2:15 pm. The Administrator, DON and a few other employees arrived just as two men from the hospital arrived. The Administrator waived them off and said no help was needed. The staff were told by the Administrator what to say and what not to say about where Resident B was found and if she was supervised. The staff feared the Administrator and of repercussion if they did not cooperate. During an interview on 6/17/26 at 10:22 a.m. CNA 6 indicated she did not answer the phone when her phone rang for an interview because she did not want to be vague. She was working on the memory care unit on 6/2/26. She observed Resident B walking down the hallways holding a blanket around 1:30 p.m. She was going out to her car around 2:10 p.m. after clocking out and was talking to another resident's spouse outside the front doors. The Administrator, DON, and the QMA/Scheduler ran out the door. She followed them and when they reached Resident B, she was lying on the grass near the road. She was further away from the facility than had been originally indicated. The staff was talking to her. She had blood on her nose and was holding her blanket tightly. They stood her up and she walked to CNA 4's car with assistance. She seemed upset with tears in her eyes and appeared confused. She only had socks on her feet. They took her back to the unit. CNA 6 indicated she stayed on the unit to complete a head count of the memory care residents. On 6/10/26, the Administrator had pulled her into her office and told her she would be interviewed soon by the Indiana Department of Health (IDOH). The Administrator suggested she not share during the interview that she had gone to the outdoor scene and indicated that the Administrator had waved her off. She asked her not to share where Resident B was found. She indicated they were going to tell IDOH that she was closer to the building. On 6/15/26 at 3:00 p.m., she received a call from the Administrator and the DON. The Administrator indicated that IDOH was about to call and asked what her answers to questions were going to be, like, did you see the contractor, what time had you checked/changed Resident B, when was the last time you saw Resident B in the hallway,' then reviewed answers to questions about where Resident B was found. She had me rehearse my answers. She reviewed the questions again after talking about the answers that should be given. During an interview on 6/17/26 at 10:57 a.m., CNA 8 indicated her written statement was true and written to be very basic, not detailed. She had gone out with the group when they came out of the building quickly and headed to the grassy field next to the parking lot. They walked quite away from the facility through the grass to an area close to the road. She noticed Resident B had some blood on her nose and was hugging her blanket as staff talked to her. After Resident B was returned by CNA 4's vehicle, she went to the memory care unit to help complete a (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	head count of all the locked unit residents. She got a call from the Administrator and DON on 6/15/26. The Administrator asked her not to say she had gone out to where Resident B was and to say she was waved off and to be vague if asked about the location Resident B was found. She had felt pressured by the Administrator to say what she requested and felt like she would be getting people in trouble if she didn't. She tried to just leave things out when completing her statement and interview. During an interview on 6/18/26 at 12:10 p.m., Dietary Aide 9 indicated he had not provided an accurate account of what occurred on 6/2/26. He indicated he had been approached by the Administrator after the elopement and it was suggested that he had eyes on Resident B when she left the building and that he witnessed her fall. The timeline was suggested and he felt pressured to cooperate because he did not want anyone to get in trouble. The truth was he pulled out of the facility parking lot (unable to recall a time) and passed by Resident B who was seated on the side of the road pretty far from the facility. He turned his vehicle around and parked across the street from where she was lying. A hospital employee walked up at the same time and went over to the resident. Dietary Aide 9 called the facility and reported where Resident B was lying in the ditch. Shortly after calling, the hospital employee indicated he was going to get help, and then CNA 4 pulled up on the other side of the road and parked. She got out of her car and went to Resident B. I left at that time. I had not seen Resident B exit the courtyard gate and had not witnessed her fall. The Administrator and DON were unavailable for a follow-up interview due to being placed on suspension during an investigation into the elopement and misinformation provided to corporate and IDOH. A current facility policy, effective 1/1/24, titled, Employee Handbook, provided by the Regional Operations Manager on 6/18/26 at 9:43 a.m., included the following: Anti-Bullying/Abuse Conduct Prevention Policy. All employees (including managers) are expected to conduct themselves in a manner that demonstrates professional conduct and mutual respect for others. Managers must make every reasonable effort to establish and maintain a workplace free of bullying and abusive conduct. A current Job Description, revised 8/21/23, titled, Administrator, provided by the Regional Nurse on 6/18/26 at 11:33 a.m., included the following: Position Summary. The Administrator leads and directs the overall operations of the facility in accordance with resident needs, government regulations and company policies so as to maintain quality care for the residents. Essential Job Functions A. Role Responsibilities: Maintain a working knowledge and insure compliance with all governmental regulations and company Quality Assurance Standards. Monitor employee relations practices of key staff to ensure compliance with employment laws and company policies. Promote practices that maintain high morale and staff retention, including effective communication, prompt problem resolution and positive reinforcement. Cross reference F689 and F9999. This citation relates to Intakes 3041631 and 3042609. 410 IAC (Indiana Administrative Code) 16.2-3.1-13(r)(1) 410 IAC (Indiana Administrative Code) 16.2-3.1-13(r)(2)		