STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155202	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Greencastle, The	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure beard restraints were worn appropriately and hand hygiene was performed after staff touched their face during 5 of 5 kitchen observations. This deficient practice had the potential to affect 68 of 68 residents who ate meals from the kitchen. Findings include: 1. During a kitchen observation, on 12/1/25 at 10:05 a.m., [NAME] 7 was observed in the food preparation area, stirring a pot on the stove and preparing other food. At the same time, [NAME] 7 was observed with a full beard and mustache. [NAME] 7 had a beard restraint in place, but it only covered a small area of the beard on his chin, leaving the mustache and sides of the face open. [NAME] 7 was wearing gloves but touched his face and nose several times with his forearm and wrist area of the glove. [NAME] 7 did not wash his hands after touching his face and nose and continued to prepare food. 2. During a lunch service observation, on 12/1/25 at 12:03 p.m., [NAME] 7 was observed serving food from the steam table in the main dining room. The beard restraint remained covering a small area of the beard on his chin, leaving the mustache and sides of the face open. [NAME] 7 was wearing gloves and wiped his nose on the back of his glove/hand three times during the meal service. [NAME] 7 did not change gloves or wash his hands after wiping his nose. 3. During a kitchen observation, on 12/3/25 at 10:12 a.m., [NAME] 7 was observed putting food in the oven. [NAME] 7 was wearing a new style beard cover which covered the sides of his face better, however, the mustache was still uncovered. 4. During a kitchen observation, on 12/3/25 at 10:43 a.m., [NAME] 7 was observed preparing the pureed lunch. [NAME] 7's mustache remained uncovered by the beard restraint during the food preparation. At the same time, Dietary Aide 10 was observed in the food preparation area with a full beard and mustache. He was wearing a beard restraint, but the mustache was uncovered. 5. During a kitchen observation, on 12/3/25 at 11:16 a.m., [NAME] 7 was observed checking the temperature of the food on the steam table. [NAME] 7's mustache remained uncovered by the beard restraint. At the same time, Dietary Aide 8 was observed putting away boxes in the walk in freezer and preparing silverware near the steam table. Dietary Aide 8 had a full beard and mustache and wore a beard restraint. The beard restraint was pulled up over Dietary Aide 8's mustache, but there was significant beard growth outside of the beard cover on the bottom of his chin and neck. [NAME] 9 was observed in the food preparation area near the stove top. [NAME] 9 had a small amount of unshaved beard/mustache growth. He was not wearing a beard cover. Dietary Aide 10 was observed putting away boxes in the walk in freezer. Dietary Aide 10's mustache remained uncovered by the beard restraint. During an interview, on 12/3/25 at 1:13 p.m., the Regional Dietary Director indicated employees' mustaches and beards needed to be completely covered. She acknowledged some of the employees had not covered their beards and mustaches completely, and she had talked with them about this. Hand hygiene should have been performed if employees touched their face or noses. On 12/3/25 at 1:45 p.m., the Regional Dietary Director provided an undated document titled, Hair Restraints., and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: Food & nutrition services employees shall wear hair restraints and beard guards.Procedure.Beard guards or masks will be worn as indicated. On 12/3/25 at 1:45 p.m., the Regional Dietary Director provided an undated document titled, Use of Disposable (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Gloves, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: Vinyl or latex gloves will be worn when handling foods that will not be further cooked to help ensure microorganisms are not transferred from food handler's hands to the food product being served. Procedure: 1. Hands are to be washed upon entering the kitchen and before putting on gloves.3. Anytime a gloved hand touches a contaminated surface, the glove must be changed, for example: a. After coughing or sneezing into hands or touching hair or face. This citation is related to Intake 2575446. 3.1-21(i)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain consent for treatment of psychotropic medications for 4 of 5 residents reviewed for unnecessary medications. (Residents 7, 8, 27, and 22). Findings include:1. On 12/3/25 at 10:25 a.m., the medical record of Resident 7 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnoses included, but were not limited to, dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), hypertension (high blood pressure) and depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks). The record did not indicate the resident had any related heart conditions. An admission Minimum Data Set (MDS) assessment, dated 4/2/25, indicated the resident was cognitively impaired and required extensive assistance with activities of daily care needs. A physician order, dated 5/31/25, indicated to administer one tablet orally of Zoloft (Sertraline HCl) 50 milligrams (mg) for depression. A physician order, dated 9/5/25, indicated to administer Seroquel (quetiapine fumarate) 150 mg by mouth two times a day for psychosis. A physician order, dated 10/15/25, indicated to administer divalproex sodium delayed release sprinkle 125 mg by mouth one time a day for mania. The record indicated that a psychotropic medication (any psychoactive drug that affects the brain's chemical makeup to treat mental and emotional disorders) had been ordered by the physician and a consent to administer the zoloft, quetiapine, divalproex sodium had not been obtained from the responsible party. Review of the psychotropic medication consents indicated an assessment was completed on 5/5/25. 2. On 12/3/25 at 11:30 a.m., medical record of Resident 8 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), hypertension (high blood pressure), anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), and depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks). A quarterly MDS assessment, dated 9/8/25, indicated the resident was cognitively impaired and required extensive assistance with activities of daily living. A physician order, dated 12/3/25, indicated to administer 1 tablet orally of Zoloft tablet 50 mg (Sertraline HCl) one time a day for depression. A physician order, dated 9/5/25, indicated to administer Seroquel (Quetiapine Fumarate) 150 mg by mouth two times a day for psychosis. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 10/10/25, indicated to administer 2 capsules orally of divalproex sodium delayed release sprinkle 125 mg one time a day for mania. A physician order, dated 10/15/25, indicated to administer 1 capsule orally of divalproex sodium delayed release sprinkle 125 mg (Divalproex Sodium) one time a day for mania. Review of the psychotropic consents indicated an assessment was completed on 5/30/25, 6/2/25 and 8/29/25. The documentation lacked evidence of notification to obtain consent from the responsible party. On 12/3/25 at 11:15 a.m., during an interview the Director of Nursing (DON) indicated the nurse who was to obtain consent for the psychotropic medications was to sign and have the MDS nurse verify education and consent was obtained. She indicated the facility identified this was not being completed and the second nurse did not verify. 3. Resident 27's record was reviewed on 12/4/25 at 11:40 a.m. The profile indicated the residents' diagnoses included, but were not limited to, major depressive disorder (a mood disorder characterized by persistent feelings of sadness and a loss of interest in activities, which interfere with daily life for at least two weeks), psychotic disorder with delusions (a mental health condition where a person holds firm, false beliefs that aren't based in reality), and Parkinson's psychosis (a non-motor symptom of Parkinson's disease that causes a break with reality, leading to seeing/hearing things not there, and/or fixed, irrational beliefs, like paranoia or infidelity). The census indicated the resident had been admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated 10/22/25, indicated the resident had moderate cognitive deficit and had no documented behaviors. A physician's order, dated 7/13/25, indicated to initiate the administration of 50 milligrams (mg) of quetiapine fumarate (a medication used to treat symptoms such as seeing or hearing things that are not real and false beliefs that are not based in reality), at bedtime. A physician's order, dated 7/13/25, indicated to initiate the administration of 100 mg of trazodone (a medication used to treat symptoms of major depressive disorder) one time daily. A physician's order, dated 7/14/25, indicated to initiate the administration of 100 mg of sertraline hydrochloride (HCl) (a medication used to treat symptoms of major depressive disorder) one time daily. The record lacked documentation that a psychotropic medication (any psychoactive drug that affects the brain's chemical makeup to treat mental and emotional disorders) consent to administer the quetiapine, sertraline, and trazodone had been obtained prior to the initiation of the medications. 4. Resident 22's record was reviewed on 12/3/25 at 1:36 p.m. The profile indicated the resident's diagnoses included, but were not limited to, active primary progressive multiple sclerosis (where disability worsens steadily over time, unlike the relapsing-remitting form, with symptoms like walking difficulty, fatigue, and cognitive issues), chronic obstructive pulmonary disease (COPD- a progressive lung disease, including emphysema and chronic bronchitis, that blocks airways, making breathing difficult due to inflammation, mucus, and damaged air sacs), and bipolar disorder (a lifelong mental (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	health condition causing extreme mood swings, from manic highs to depressive lows). A quarterly Minimum Data Set (MDS) assessment, dated 9/23/25, indicated the resident was cognitively intact and received anti-psychotic (used primarily for psychosis) and anti-depressant medications. A care plan, dated 7/3/18, indicated the resident had a diagnosis of bipolar disorder. Interventions included, but were not limited to, medication administration and continue current mental health services. A care plan, dated 3/12/19, indicated the resident was at risk for behavioral disturbances related to diagnosis of bipolar, including racing thoughts and mood swings. Interventions included, but were not limited to, monitor for effectiveness of meds and interventions, gradual dose reduction per guidelines, and antipsychotic meds per order. A physician order, dated 5/29/25, indicated to administer Zoloft (anti-depressant) 50 mg, one tablet by mouth one time a day for depression. A progress note, dated 5/29/25 at 1:55 p.m., new orders received to start Zoloft and increase dose over the next few months. The record lacked documentation of a psychotropic medication consent being obtained with the initiation of a new psychotropic medication (Zoloft). During an interview on 12/3/25 at 2:42 p.m., Director of Nursing (DON) indicated she was not aware if a psychotropic medication consent had been obtained prior to when Resident 22 started the new medication. During an interview on 12/4/25 at 10:49 a.m., the DON indicated she could not find a psychotropic consent for when the Zoloft medication was initiated. She was aware that psychotropic medication consents should be completed with the initiation of a new psychotropic medication and/or when there was an increase in the dosage. During an interview, on 12/3/25 at 11:15 a.m., the Director of Nursing (DON) indicated the nurse who was responsible to obtain the consent for the psychotropic medications was to sign and have the MDS nurse verify education, and consent had been obtained. On 12/4/25 at 11:40 a.m., the DON provided an undated document, titled, Guidelines for Psychotropic Medication, and indicated it was the policy currently being used by the facility. The policy indicated, .Obtain informed consent.from the resident and/or representative.and document education.for any change in dose, one form per medication. 3.1-3(n)(2)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to ensure the grievances expressed by the residents were addressed and resolutions were explained to the residents for 6 of 24 residents reviewed for food concerns (Residents 6, 71, 38, 24, 68, and 65). Findings include:During an interview, on 12/01/25 at 11:19 a.m., Resident 6 indicated she ate in her room. The food was often cold when she got it. The residents were not getting the food that was posted on the menus. The menu had not been right for a while. She was not sure who was ordering the food, but they frequently ran out of items. They recently had run out of coffee. During an interview, on 12/02/25 at 10:52 a.m., Resident 71 indicated he did not like the food and when he asked for an alternative, he was told they did not have any. There were times when all he wanted was peanut butter and jelly and the kitchen staff told him they did not have any peanut butter. During an interview, on 12/02/25 at 11:20 a.m., Resident 38 indicated he had to buy himself his own peanut butter, jelly, and bread so that he would have something to eat. He had eaten both in the dining room and in his room. The food was sometimes cold when it was delivered to his room. During an interview, on 12/02/25 at 1:48 p.m., Resident 24 indicated the food was never what was posted on the menu. They recently had no coffee for two days. They had not had many vegetables for quite some time and serve mac and cheese all the time. The food was often cold. He would have his family bring him salads to eat because the kitchen didn't have much. One time they only gave him five tater tots and two slices of bread with lettuce on it for a meal. There was not any meat on the sandwich at all. During an interview, on 12/3/25 at 10:43 a.m. [NAME] 7 indicated there have been issues with the kitchen running out of things at times. They had run out of coffee before. He didn't believe they were able to get ice cream anymore. He thought it had been because they had been in between Dietary Managers, and that position oversaw ordering the food. The corporate support had been trying to help right now while they didn't have a manager. During an interview, on 12/3/25 at 1:13 p.m. the Regional Director of Dietary acknowledged they had run out of coffee and pink sweetener because one of their trucks didn't come in. She denied running out of other things. On 12/04/25 at 10:09 a.m., the Resident Council interview was conducted. The primary concerns voiced by the members of the Council were related to the kitchen and the food. During the Resident Council interview, on 12/04/25 at 10:22 a.m., Resident 68 indicated there had been concerns with the kitchen running out of items like coffee, creamer, and orange juice. The residents had brought this up multiple times in the Resident Council meetings but were still having issues. During the Resident Council interview, on 12/04/25 at 10:26 a.m., Resident 65 indicated the Council had brought several concerns to the facility, but the food issues had been ongoing. She did not wish to cause anyone any trouble or make anyone unhappy. They used to meet with the kitchen staff to discuss the issues, but that stopped when the manager of the kitchen stopped attending. She no longer worked at the facility, and she was unsure if they even had anyone in charge in the kitchen anymore. During an interview, on 12/04/25 at 10:35 a.m., the Activity Director indicated she was always invited by the Resident Council to attend their meetings to take the minutes. They used to have a food council and would get together with the Dietary Manager to air their concerns. That was about two Dietary Managers ago. The Dietary Manager eventually stopped coming to the meetings and the council just stopped meeting. Now there was a new contracted group who oversaw the kitchen. They have had a hard time keeping a manager in the kitchen. She did remember when the kitchen ran out of coffee. It was on a weekend. One of the staff had suggested going out and buying some coffee, but was told that, because the kitchen was run by a contracted company, they may not get reimbursed for it and it would be considered a donation. During an interview, on 12/4/25 at 3:00 p.m., the Administrator (ADM) indicated she had been given the food concerns by the Resident Council. She had interviewed the Resident Council President who had told her there were no longer concerns and she felt like that the members of the Council were content with the situation. When the next meeting brought forth more concerns, she made sure that the sub-contracted company was made aware and (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had addressed the concerns. They had indicated the items had been ordered but were out of stock. She had not attended any of the Resident Council meetings to address the concerns directly. On 12/4/25 at 3:00 p.m., the ADM provided a document, with a revision date of 2/9/16, titled, Resident Council Policy, and indicated it was the policy currently used by the facility. The policy indicated, .The Resident Council offers an avenue by which resident can have an active role in influencing decisions which affect them.Some objectives of the council are as follows: .C. Helps to identify quality of life issues.Regulations.6. When a resident.group exists, the facility must listen to the views and act upon the grievances and recommendations of residents.concerning proposed policy and operational decisions affecting resident care and life in the facility. On 12/4/25 at 3:00 p.m., the ADM provided an undated document, titled, I Would Like To Know., and indicated it was the policy currently in use by the facility. The policy indicated, .1. When a resident.presents a question/concern, a staff member will obtain the I Would Like To Know. form.3. During the following morning meeting, the Administrator or designee reads the.form to the CQI committee and logs the questions/concern on the tracking form.6.the Administrator or designee will review the log and the status of the unanswered questions/concerns will be discussed. The objective being to answer all logged questions/concerns as soon as possible.10. When the question/concern has been resolved or has been resolved to the greatest possible extent, the assigned Department Head will contact the appropriate party to discuss what has been done. 3.1-3(a)3.1-3(g)3.1-3(k)3.1-3(l)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Abnormal Involuntary Movement Scale (AIMS) (a clinical tool to detect and monitor tardive dyskinesia (TD) in patients taking (antipsychotic) medications, rating involuntary facial, limb, and trunk movements) assessments were completed timely for 2 of 5 residents reviewed for unnecessary medications (Residents 7 and 22).Findings include:1. On 12/3/25 at 10:25 a.m., the medical record of Resident 7 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnoses included, but were not limited to, dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), hypertension (high blood pressure), and depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks). The record did not indicate the resident had any related heart conditions. An admission Minimum Data (MDS) assessment, dated 4/2/25, indicated the resident was cognitively impaired and required extensive assistance with activities of daily care needs. The medical record indicated an AIMS assessment was completed on 4/2/25. Documentation lacked evidence of an assessment completion every 6 months. On 12/3/25 at 11:30 a.m., medical record of Resident 8 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), hypertension (high blood pressure), anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), and depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks). A quarterly MDS assessment, dated 9/8/25, indicated the resident was cognitively impaired and required extensive assistance with activities of daily living. The medical record indicated an AIMS assessment was completed on 2/18/25 and 11/20/25. The record lacked evidence of the assessments being completed timely. On 12/3/25 at 11:15 a.m., during an interview the Director of Nursing (DON) indicated she would have to check the policy for AIMS assessments. 2. Resident 22's record was reviewed on 12/3/25 at 1:36 p.m. The profile indicated the resident's diagnoses included, but were not limited to, active primary progressive multiple sclerosis (where disability worsens steadily over time, unlike the relapsing-remitting form, with symptoms like walking difficulty, fatigue, and cognitive issues), chronic obstructive pulmonary disease (a progressive lung disease, including emphysema and chronic bronchitis, that blocks airways, making breathing difficult due to inflammation, mucus, and damaged air sacs), and bipolar disorder (a lifelong mental health condition causing extreme mood swings, from manic highs to depressive lows). Facility census information indicated Resident 22 admitted to the facility on [DATE]. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS) assessment, dated 9/23/25, indicated the resident was cognitively intact and received anti-psychotic (used primarily for psychosis) and anti-depressant medications. A care plan, dated 7/3/18, indicated the resident had a diagnosis of bipolar disorder. Interventions included, but were not limited to, medication administration and continue current mental health services. A care plan, dated 3/12/19, indicated the resident was at risk for behavioral disturbances related to diagnosis of bipolar, including racing thoughts and mood swings. Interventions included, but were not limited to, monitor for effectiveness of meds and interventions, gradual dose reduction per guidelines, and antipsychotic meds per order. A physician order, dated 11/21/24 with a stop date of 3/31/25, indicated to administer Zyprexa (anti-psychotic medication) 12.5 milligram (mg), by mouth at bedtime. A physician order, dated 4/1/25, indicated to administer Zyprexa10 mg, one tablet by mouth once a day for bipolar disorder. Review of Resident 22's record indicated an AIMS (Abnormal Involuntary Movement Scale) assessment had been completed on 3/25/25 but the record lacked documentation of an AIMS assessment being completed since 3/25/25. During an interview on 12/4/25 at 2:53 p.m., Registered Nurse (RN) 12 indicated the nurses working the floor were responsible for completing the AIMS assessments on the residents who were on anti-psychotic medications. The AIMS assessments were documented in the resident's electronic health record under the assessments tab. During an interview on 12/4/25 at 2:54 p.m., Licensed Practical Nurse (LPN) 16 indicated the AIMS assessments were to be completed every 6 months on the residents who were on anti-psychotic medications. On 12/4/25 at 9:22 a.m., the Administrator provided an undated document, titled, Guidelines for Abnormal Involuntary Movement Scare (AIMS), and indicated it was the policy currently being used by the facility. The policy indicated, .residents receiving psychotropic medication will have an AIMS assessment performed at intervals no less than every 6 months.2. The AIMS will be completed no less than every 6 months; however it should be completed every time the resident appears to be displaying increased symptoms of Tardive Dyskinesia (a neurological disorder causing involuntary, repetitive movements). 31-48(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessment for 2 of 17 reviewed (Residents 22 and 65).Findings include: 1. Resident 22's record was reviewed on 12/3/25 at 1:36 p.m. The profile indicated the resident's diagnoses included, but were not limited to, active primary progressive multiple sclerosis (MS - where disability worsens steadily over time, unlike the relapsing-remitting form, with symptoms like walking difficulty, fatigue, and cognitive issues), chronic obstructive pulmonary disease (COPD - a progressive lung disease, including emphysema and chronic bronchitis, that blocks airways, making breathing difficult due to inflammation, mucus, and damaged air sacs), and bipolar disorder (a lifelong mental health condition causing extreme mood swings, from manic highs to depressive lows). Facility census information indicated Resident 22 admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated 9/23/25, indicated the resident was cognitively intact and was marked No the resident did not have a condition or chronic disease that may result in a life expectancy of less than 6 months. A physician order, dated 6/12/24 at 10:25 a.m., indicated the physician gave verbal certification that Resident 22 had a prognosis of less than 6 months if the disease runs its normal course. A physician order, dated 6/13/24, indicated to admit the resident to hospice services for a diagnosis of MS. A care plan, dated 6/15/24, indicated the resident received hospice services. The interventions included, but were not limited to, hospice services as ordered and notify hospice nurse of any new orders or changes in condition. During an interview on 12/2/25 at 9:44 a.m., the MDS Coordinator indicated she could not remember when Resident 22 went on hospice services and she would have to look back at her medical record to see. She indicated a modification would have to be completed on the resident's most recent quarterly MDS assessment since it was not coded correctly. The MDS Coordinator indicated she was new at her position and would have to seek guidance from her corporate advisor since she had never had to complete a modification yet. When a resident was on hospice the MDS assessment should have been marked as Yes. Section J1400 of the CMS (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated October 2024, indicated .Prognosis: Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? . Code 1, yes: if the medical records include physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services. 2. Resident 65's record was reviewed on 12/4/25 at 10:58 a.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a progressive lung disease, including emphysema and chronic bronchitis, that blocks airways, making breathing difficult due to inflammation, mucus, and damaged air sacs) and heart failure (occurs when the heart can't pump enough blood to meet the body's needs, leading to symptoms like shortness of (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Greencastle, The	1601 Hospital Dr Greencastle, IN 46135

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breath, fatigue, and swelling in legs/ankles, often caused by damage from heart attacks, coronary artery disease, or high blood pressure). Facility census information indicated Resident 65 admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated 9/27/25, indicated the resident had moderate cognitive impairment and did not use a non-invasive mechanical ventilator. A physician order, dated 3/19/24, indicated to place CPAP (continuous positive airway pressure, a common medical treatment especially for obstructive sleep apnea) at bedtime for sleep apnea and help resident place CPAP on every bedtime. Review of September MAR (medication administration record) indicated Resident 65 had used the CPAP every night. The MAR lacked documentation of the resident's refusal to wear the CPAP at night. A care plan, dated 2/9/24, indicated the resident was at risk for shortness of breath due to diagnosis of COPD. Interventions included, but were not limited to, elevate head of bed for comfort and meds per order. A care plan, dated 2/9/24, indicated the resident had obstructive sleep apnea related to diagnosis of COPD. Interventions included, but were not limited to, CPAP at night per order and observe for signs and symptoms of low Oxygen. During an interview on 12/5/25 at 9:50 a.m., the Director of Nursing (DON) was not aware of how the MDS should be coded for a resident who used a CPAP machine, she would have to speak with the corporate MDS Coordinator. During an interview, on 12/5/25 at 9:57 a.m., the MDS Coordinator indicated Resident 65's most recent quarterly assessment was not coded currently and should have been marked yes the resident used a non-invasive mechanical ventilation device. The MDS assessment would have to be modified. Section O0110 of the CMS (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated October 2024, indicated, .Special Treatments, Procedures, and Programs:.O0110G1: Non-invasive Mechanical Ventilator: Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing. O0110G3, CPAP: Check is the non-invasive mechanical ventilator support was CPAP.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a care plan was developed related to weight loss (Resident 7), failed to ensure a care plan was developed related skin concerns (Resident 71), and failed to ensure documentation of care plan meeting being held (Resident 19) for 3 of 24 residents reviewed for care plans. Findings include: 1. On 12/1/25 at 11:58 a.m., during initial observation observed Resident 7 in the main dining room being assisted with meal. The Certified Nurse Aide (CNA) started to assist the resident with the meal. CNA left to assist other residents. Resident continued to pick at food. Did not seem to know what to do with utensils. At 12:08 p.m., the CNA returned and assisted the resident again. The CNA began to feed the resident at that time. On 12/3/25 at 10:25 a.m., the medical record of Resident 7 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnoses included but were not limited to dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), hypertension (high blood pressure) and depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks). The record did not indicate the resident had any related heart conditions. An admission Minimum Data Assessment (MDS), dated [DATE], indicated the resident was cognitively impaired and required extensive assistance with activities of daily care needs including eating. A care plan, dated 4/4/25 with a revision date of 10/26/25, indicated the resident was above ideal body weight. Included medical problems which may predispose him/her to weight gain. The care plan goal indicated the resident will experience no further weight gain by the next review date. Interventions included, but were not limited to, prepare and serve the resident's nutritional diet as ordered, determine food preferences through resident and family interview, weigh resident monthly, and notify physician of weight changes greater than 5% in one month. Review of the weight record from 4/2/25 to 12/2/25 indicated 10.66 % weight loss since admission. The record indicated a physician order, dated 10/28/25, to administer health shakes two times a day. A care plan with a revision, date 10/26/25, indicated the resident was above ideal body weight (IBW) range and confounding factors include medical problems which may predispose him/her to weight gain, and was on a therapeutic diet. The care plan lacked documentation of a care plan addressing weight loss. On 12/3/25 at 11:15 a.m., during an interview the Director of Nursing (DON) indicated the MDS nurse typically wrote and revised care plans. She was not sure why the care plan had not been updated to reflect the 10.66% weight loss in 6 months. On 12/3/25 at 1:50 p.m., during an interview the DON indicated the dietitian had indicated the resident's weight gain was related to fluid. She did not know why the care plan had not been revised to include weight loss and did not include updated interventions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 12/2/25 at 10:52 a.m., during initial observation and interview, Resident 71 was observed to have an open and scabbed area on the top of his nose. The resident indicated it was cancer. On 12/3/25 at 1:00 p.m., the medical record of Resident 71 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included ,but were not limited to, type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), bipolar disorder (formerly called manic-depressive illness or manic depression a mental illness that causes unusual shifts in a person's mood), and dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) A quarterly MDS, dated [DATE], indicated the resident had limited cognition and no skin related condition other than cancer. A physician order, dated 7/30/25, indicated to apply Mupirocin External Ointment 2 % (Mupirocin) to the nose topically one time a day for open area on nose, after applying mupirocin leave open to air until healed. The order indicated to also apply to nose topically at bedtime for open area on nose at hour of sleep after applying mupirocin, cover with band-aid, until healed. A care plan dated 7/7/25 indicated the resident was at risk for skin breakdown due to weakness, incontinence. Interventions included braden scale quarterly and as needed, keep clean and dry, pressure relieving mattress per facility policy, preventative treatment as ordered and skin assessment per facility policy. The care plan lacked documentation of a care plan addressing the skin lesion on the resident's nose. On 12/3/25 at 2:00 p.m., during an interview the DON indicated Resident 71 had a cancerous lesion on his nose and was being treated by a dermatologist. On 12/4/25 at 1:00 p.m., during an interview the DON indicated she did not know if the lesion on the resident's nose was cancerous and did not know if a care plan was in place. 3. During the initial interview, on 12/01/25 at 2:15 p.m., Resident 19 indicated he did not remember having a care plan meeting. Resident 19's record was reviewed on 12/3/25 at 10:02 a.m. The profile indicated the resident's diagnoses included, but were not limited to, completed traumatic amputation at level between the knee and ankle or right lower leg (the right lower leg was completely severed by an injury or trauma) and diabetes mellitus (a chronic disease where the body has high blood sugar levels). An admission Minimum Data Set (MDS) assessment, dated 10/22/25, indicated the resident had no cognitive deficit. The resident's record lacked documentation of any care plan meeting being held. During an interview, on 12/04/25 at 10:43 a.m., the Social Services Director (SSD) indicated she had documentation of the resident's scheduled care plan meeting on her cell phone. She understood that the meeting should have been documented in the resident's medical record. She could not determine why she had not documented the meeting in the record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/25 at 3:05 p.m., the Administrator provided an undated document, titled, Baseline Care Plan Assessment/Comprehensive Care Plan, and indicated it was the policy currently being used by the facility. The policy indicated, .6. The facility Social Services Director or designee will notify the resident of their scheduled care plan conference and will invite and encourage the resident to attend.These notifications will be document for reference.8.An IDT note will be made in reference to the meeting to include who attended, significant changes addressed and date and time of the meeting. 3.1-35(c)(1) 3.1-35(c)(2)(C) 3.1-35(e)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 1 of 4 residents (Resident 19) observed during the medication pass. There were 32 opportunities for error observed with 4 medication errors, resulting in a medication error rate of 12.5 percent. Findings include: On 12/3/25 at 9:31 a.m., Registered Nurse (RN) 12 administered medications to Resident 19. The medications included, but were not limited to, fluticasone-salmeterol aerosol (medication to ease breathing) inhaler 250-50 micrograms (mcg) 1 puff and tiotropium bromide inhaler (relaxes and opens air passages) aerosol 2.5 mcg 1 puff. RN 12 handed the resident the inhalers, and he took 1 puff of each. The resident did not rinse and spit after the fluticasone propionate inhaler and was not prompted by RN 12 to do so. The inhalers were administered one after the other, with no wait time between the two. Aspirin 81 milligrams (mg) and cetirizine 10 mg were not administered. At the same time, RN 12 indicated the resident was out of aspirin 81 mg and cetirizine 10 mg. RN 12 usually finished her medication pass and then pulled any other needed medications from the emergency drug kit (EDK). Resident 19's record was reviewed on 12/4/25 at 11:15 a.m. A physician's order, dated 10/16/25, indicated tiotropium bromide inhalation aerosol solution 2.5 mcg, 2 puffs inhaled orally once daily for shortness of breath. A physician's order, dated 10/16/25, indicated aspirin chewable 81 mg, give 1 tablet once daily for blood thinner. A physician's order, dated 10/16/25, indicated cetirizine 10 mg, give 1 tablet by mouth once daily for allergy symptoms. A physician's order, dated 10/20/25, indicated fluticasone-salmeterol aerosol powder breath activated 250-50 mcg/dose inhaler, 1 puff inhaled orally every 12 hours for shortness of breath. Medication administration progress notes, dated 12/3/25, indicated the aspirin 81 mg and cetirizine 10 mg were out of stock. The pharmacy was called to verify the refill status, medication would arrive later that evening, the physician was aware. The progress notes lacked documentation RN 12 attempted to pull the medications from the EDK or a physician's order was obtained to hold the medications or administer them when they arrived from pharmacy. During an interview, on 12/3/25 at 9:56 a.m., RN 12 indicated the resident did not normally swish and spit after the fluticasone-salmeterol inhaler, and she was not sure if he should have or not. The resident may have only done one puff of the tiotropium bromide inhaler, but she was not sure. The resident was supposed to inhale two puffs of the tiotropium bromide inhaler. During an interview, on 12/3/25 at 10:59 a.m., the Director of Nursing (DON) indicated she would have to check the policy on the fluticasone-salmeterol inhaler to see if the resident should have swished and spit afterwards. During an interview, on 12/4/25 at 11:10 a.m., the DON indicated medications should have been pulled from the EDK and administered as ordered, if they were available. On 12/3/25 at 11:57 a.m., the Administrator provided the Food and Drug Administration (FDA) drug information for the fluticasone salmeterol inhaler, dated 1/7/19, and indicated it was the guidance currently being used by the facility. The guidance indicated, .Candida albicans (yeast) infection of the mouth and pharynx [throat] may occur. Monitor patients periodically. Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk. On 12/3/25 at 1:10 p.m., the Administrator provided an untitled/undated document and indicated it was the list of medications available in the EDK. The list indicated aspirin 81 mg chewable tablets were available. On 12/3/25 at 1:10 p.m., the Administrator provided a document titled, Medication Administration, dated February 2017, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To administer all medications safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis.Procedure.11. Read and follow any special instructions written on labels.17. Give the resident the medication.24. If the medication is ordered but not present, call the pharmacy or supervisor to obtain the medication. On 12/3/25 at 1:10 p.m., the Administrator provided a document titled, Inhalation (Oral and Nasal) Administration, dated July 2024, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: Oral.inhalation (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication will be administered according to physician's orders using safe and sanitary practices. Procedures: Oral Inhalation.2. Check the product directions, and shake inhaler well before each use of manufacture directions allow.6. Ask the resident to: a. Exhale completely b. Breathe in deeply and slowly through his/her mouth while fully depressing the top of the canister with index finger c. Hold his/her breath as long as it is comfortable before exhaling.8. If more than one inhalation is ordered, wait one minute, and then repeat steps 2 through 7 above for each inhalation ordered. 9. If specified by the manufacture, rinse patient's mouth with water after last inhalation. 3.1-48(c)(1)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to document resident refusal or justification for holding insulin, and failed to document notification to the physician for 1of 1 resident reviewed for unnecessary medications (Resident 8). Findings include:On 12/04/25 at 10:00 a.m., the medical record of Resident 8 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included but was not limited to, type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high). A quarterly Minimum Data Assessment (MDS), dated [DATE], indicated the resident was cognitively impaired and received daily insulin injections. A care plan, dated 11/22/22, indicated diabetes with risk for hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). Interventions included, but not limited to, antidiabetic medications per order, and notify physician and family as needed. A physician order, dated 7/24/25, indicated to administer Lantus SoloStar Solution Pen-injector 100 UNIT/ML (Insulin Glargine) inject 10 unit subcutaneously (under the skin) at bedtime for diabetes mellitus. The medication administration record for the months of October 2025 and November 2025 indicated Lantus insulin was not administered on 10/30/25, 11/1/25, 11/2/25, and 11/27/25. The record lacked documentation of resident refusal, justification for holding the insulin, or notification to the physician. On 12/3/25 at 1:50 p.m., during an interview the Director of Nursing (DON) indicated if a nurse would hold an insulin administration it would depend on the resident if the nurse would need to notify the physician. She indicated it would be the same for holding Lantus insulin. On 12/4/25 at 10:19 a.m., during an interview with Registered Nurse (RN) (12) the nurse indicated she would write a progress note and notify the physician of the request to hold insulin, and she would notify the physician if a resident refused insulin. On 12/4/25 at 10:22 a.m., during an interview RN (13), indicated she would notify the physician and ask for parameters to hold insulin. She indicated she would notify the physician if a resident refused to allow administration of insulin. She indicated Resident 8 did not often refuse her insulin. On12/4/25 at11:27 a.m., the provided an undated document, titled, Physician Orders - (following physician orders), and indicated it was the policy currently being used by the facility. The policy indicated, .Policy.It is the policy of the facility to follow the orders of the physician. 3.1-50(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure hand hygiene was performed during the medication pass for 3 of 4 residents reviewed on the medication pass (Residents 19, 26, and 67). Findings include: During a continuous medication pass observation, on 12/3/25 from 9:31 a.m. to 9:52 a.m., the following was observed. -Registered Nurse (RN) 12 prepared and administered medication to Resident 19. The medication included a nasal spray, two inhalers, and application of lidocaine patches (topical pain reliever). RN 12 wore gloves during the medication administration but did not perform hand hygiene before, or after, the medication administration. -RN 12 then prepared and administered medication to Resident 26. No hand hygiene was performed before or after the medication administration. -RN 12 then prepared and administered medication to Resident 67. The medication included eye drops. RN 12 wore gloves while administering the eye drops but did not perform hand hygiene before, or after, the medication administration. During an interview, on 12/3/25 at 9:56 a.m., RN 12 indicated she should have used hand sanitizer between residents. During an interview, on 12/3/25 at 10:59 a.m., the Director of Nursing (DON) indicated the staff should have used hand sanitizer between residents. She was not sure when they would have to wash their hands instead of using hand sanitizer, but she would check the policy. During an interview, on 12/4/25 at 1:45 p.m., the Infection Preventionist (IP) indicated hand sanitizer should have been used between residents on the medication pass and after procedures that required gloves. On 12/3/25 at 1:10 p.m., the Administrator provided a document titled, Medication Administration, dated February 2017, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To administer all medications safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis.Before the Medication Pass.2. Cleanse your hands before beginning and before contact with each resident.Procedure: 1. Wash hands before beginning, whenever you contaminate your hands, and if contact is made with the medication. On 12/3/25 at 1:10 p.m., the Administrator provided a document titled, Inhalation (Oral and Nasal) Administration, dated July 2024, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: Oral and nasal inhalation will be administered according to physician's orders using safe and sanitary practices. Procedures: Oral Inhalation: 1. Cleanse hands before and after medication administration.Nasal Inhalation: 1. Cleanse hands before and after medication administration. On 12/3/25 at 1:10 p.m., the Administrator provided a document titled, Eye Drop Administration, dated July 2024, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: The appropriate and safe administration of liquid ophthalmic medication (eye drops).for therapeutic treatment, or for help in the production of tears. Procedure.2. Proper hand washing before and after administration of medication. 3.1-18(l)