STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155304	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of New Castle, The	1000 N 16th St New Castle, IN 47362

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to ensure residents were free from a significant medication error when Resident B and Resident C received each others evening medications for 2 of 4 residents reviewed for medication error (Resident B and Resident D). Finding include: 1.Review of the record of Resident B, on 2/17/26 at 10:45 a.m., indicated the resident's diagnoses included, but were not limited to, diabetes, major depression disorder, chronic kidney disease (Kidneys are damaged and unable to efficiently filter waste and excess fluid from the blood) and peripheral vascular disease (circulation disorder involving narrowing or blockage of blood vessels).The admission Minimum Data Set (MDS) assessment for Resident B, dated 1/20/26, indicated the resident was cognitively intact for daily decision making. The physician's medication orders for Resident B, on 1/25/26, indicated the resident was prescribed the following medications at bedtime: carvedilol (blood pressure medication) 25 mg, fenofibrate (cholesterol medication) 145 mg, gabapentin (treatment for nerve pain) and oxycodone (opioid pain medication) 10 mg. On 1/25/26, the resident had not received the prescribed medications. Resident B was administered the following medications in error, on 1/25/26 at bedtime, Tylenol (over the counter pain medication) 500 milligrams (mg) two tablets, baclofen (muscle relaxer) 10 mg, clonazepam (antianxiety medication) 0.5 mg, ferrous sulfate (iron supplement) 325 mg, florastor (probiotic) 250 mg, guaifenesin (over the counter treatment for chest congestion) 200 mg, remeron (antidepressant) 15 mg, pantoprazole (over the counter medication for reducing stomach acid), tamsulosin (medication to improve urinary flow) and geodon (antipsychotic) 60 mg. The progress note for Resident B, dated 1/26/26 at 8:50 a.m., indicated the Director of Nursing (DON) was notified by the resident and his family member at bedside, that he had received another resident's medication at bedtime last evening. Resident stated he felt very tired and sleepy this am. Resident was alert and oriented at that time, responding appropriately. The Medical Director was notified. New orders were obtained to monitor vital signs and complete Neurological assessments every 4 hours for 12 hours and to notify the Medical Director if the resident experienced any change in his condition. There were no abnormal vital signs or neurological assessments documented for Resident B on 1/26/26. 2.Review of the record of Resident C on 2/17/26 at 11:26 a.m., indicated the resident's diagnoses included, but were not limited to, borderline personality (instability in moods), cerebral palsy (neurological disorder affecting body movements), anxiety, psychotic disorder (loss of contact with reality), dementia (decline in mental ability) and muscle weakness. The resident was allergic to haldol (antipsychotic medication) and prozac (antidepressant). The quarterly MDS assessment for Resident C, dated 2/9/26, indicated the resident was severely impaired for daily decision making.The physician's medication orders for Resident C, on 1/25/26, indicated the resident was prescribed the following medications at bedtime: Tylenol 500 milligrams (mg) two tablets, baclofen 10 mg, clonazepam 0.5 mg, ferrous sulfate 325 mg, florastor 250 mg, guaifenesin 200 mg, remeron 15 mg, pantoprazole, tamsulosin and geodon 60 mg. On 1/25/26, the resident had not received the prescribed medications. Resident C was administered (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following medications in error, on 1/25/26 at bedtime, carvedilol 25 mg, fenofibrate 145 mg, gabapentin and oxycodone 10 mg. The progress note for Resident C, dated 1/26/26 at 8:50 a.m., indicated the DON was notified that the resident may have received another resident's medication. The resident was alert and oriented to self and staff per baseline. The Medical Director was notified. New orders were obtained to monitor vital signs and complete Neurological assessments every 4 hours for 12 hours and to notify the Medical Director if the resident experienced any change in his condition. There were no abnormal vital signs or neurological assessments documented for Resident C on 1/26/26. During an interview with the Nurse Practitioner (NP) on 2/17/26 at 11:55 a.m., indicated she was Resident C's primary care provider and was notified of the resident receiving Resident B's medication on 1/25/26. The NP assessed the resident and he looked great, his vital signs were stable. There was no indication that Resident C required lab work or hospitalization. The resident remained at his baselineDuring an interview with the Medical Director on 2/17/26 at 12:05 p.m., He indicated he was notified of Resident B and Resident C receiving each other's medication on the evening of 1/25/26. The Medical Director reviewed the medications and ordered vital signs and neurological assessments for both residents. Resident B and Resident C remained at baseline and had no abnormal vital signs or abnormal neurological assessments. There were no concerns about health or safety for either resident. The facility monitored the residents closely and kept him informed every hour. There were no side effects for either resident, and there was no indication for laboratory test to be drawn or hospitalization. During an interview with the DON on 2/17/26 at 12:10 p.m., RN 1 preset up Resident B and Resident C's medication and put them in a medication cup on the evening of 1/25/26. Resident B questioned RN 1 that he did not normally take that many medications in the evening time but went ahead and took the medications. RN 1 had gotten Resident B and Resident C's medication cups mixed up. Resident B and Resident C's vital signs remained stable and there were no abnormal neurological assessments. During an observation on 2/17/26 at 11:15 a.m., Resident B and Resident C's rooms were next to each other. Resident C was in his room sitting in his wheelchair, the resident was nonverbal. The medication administration policy provided by the Administrator on 2/17/26 at 12:35 p.m., indicated the procedure included, but were not limited to the following, verify that there was a physician's order for the medication, check the label on the medication and confirm the medication name and dose with the Medication Administration Record (MAR), check the medication dose and re-check to confirm the proper dose and confirm the identity of the resident. This deficient practice was corrected on 2/5/26, prior to the start of the survey, and was therefore past noncompliance. The facility implemented a systemic plan that included the following actions: in-service education was provided to all licensed nurses and QMA's to ensure medications were provided to residents in a safe and accurate manner and an medication pass observation of all licensed nurses and QMA's was completed by the Director Of Nursing (DON) prior to administering medications to residents without oversight of the DON. The facility continues ongoing reviews with annual competency skill checks of medication administration. This citation relates to Intake 2728799.