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	04/14/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to transfer a resident with a mechanical lift in a safe manner resulting in the resident sustaining a laceration to the forehead requiring 5 stitches and an acute fracture above the knee for 1 of 3 residents reviewed for accidents (Resident D). Finding include:Review of the record of Resident D on 4/13/26 at 12:00 p.m., indicated the resident's diagnoses included, but were not limited to; dated 2/13/26, acquired absence of left leg below the knee amputation; dated 3/27/26, laceration to the forehead requiring 5 stitches; and dated 4/6/26, an acute comminuted angulated fracture involving the distal femoral metaphysis of the left leg acute fracture above the left knee (above the knee fractured bone caused by trauma) and end stage renal disease requiring dialysis (a procedure to remove waste and excess fluid from the blood). The plan of care for Resident D, dated 1/8/2026, indicated the resident had been determined to require a mechanical lift (a mechanical, hydraulic, or electric patient lifting device used to transfer individuals with limited mobility) for safe transfers. The interventions included, but were not limited to, two staff would transfer the resident using the mechanical lift. The fall assessment for Resident D, dated 2/2426, indicated the resident was at high risk for falls. The quarterly Minimum Data Set (MDS) for Resident D, dated 3/3/26, indicated the resident was cognitively intact for daily decision making. The resident was dependent on staff for transfers and the resident had no history of falls. The Progress Note for Resident D, dated 3/27/26 at 5:35 a.m., indicated the resident was lying on the floor on her back. Resident D reported that she slid forward out of the mechanical lift. The resident was immediately sent to the emergency room. The emergency department note for Resident D, dated 3/27/26 at 5:43 a.m., indicated the resident was dropped headfirst from a mechanical lift at the facility. Resident D complained of head, neck, and back pain. The resident had a 3.0-centimeter (cm) laceration with indentation to the left frontal scalp. Resident D had a Computed Tomography (CT) scan of the head and spine that was negative for acute intracranial abnormality or spine fracture. The resident had a head laceration repair with five stitches and discharged back to the facility. The employee statement for CNA 4, dated 3/27/26 (no time), indicated Resident D was in bed and CNA 4 hooked up with all 4 straps to the mechanical lift and CNA 4 began to transfer the resident. Resident D leaned forward and came out of the mechanical lift sling. CNA 4 indicated she thought everyone was busy and wanted to get Resident D up in the wheelchair to eat breakfast before the resident went to dialysis. The employee statement for LPN 5, dated 3/27/26 at 5:35 p.m., indicated he was passing medication when he heard a loud noise, as if someone had fallen. LPN 5 headed towards the commotion and heard his name being called out for help. LPN 5 entered Resident D's room and discovered her lying on the floor on her left side. Resident D had a large gash to her forehead and was complaining of back pain. LPN 5 applied pressure to the wound but was unable to stop the bleeding. Resident D was transferred to a stretcher and transported to the emergency room. The Progress Note for Resident D, dated 3/27/26 at 7:00 a.m., indicated the resident returned from the emergency room accompanied by her family. The resident had a laceration on the forehead with 5 stitches. The resident and family did not want the resident to go to her scheduled dialysis appointment. The dialysis center was notified. Resident D was resting in bed. The Progress Note for Resident D, dated 4/6/26 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	at 12:18 p.m., indicated the facility transport driver went to pick up Resident D from dialysis and was notified the resident had been sent to the emergency room due to the resident had requested at least 5 times to be sent to the hospital. The Progress Note for Resident D, dated 4/6/26 at 2:20 p.m., indicated the dialysis staff notified the transport driver at 12:00 p.m., that Resident D was sent from the dialysis center by ambulance to the emergency room due to left leg pain. The emergency room report for Resident D, dated 4/6/26 at 2:26 p.m., indicated Resident D fell in March 2026 and experiencing status post left leg pain. An x-ray was completed of the left knee, and the resident had an acute comminuted angulated fracture involving the distal femoral metaphysis. The resident's weight was 139.9 pounds, and her height was 60.98 inches tall. During an observation on 4/13/26 at 1:13 p.m., Resident D was being assisted by staff with eating lunch. The resident had a laceration on her forehead that was scabbed and the resident's face was bruised black and blue around her right eye and forehead. During an observation on 4/13/26 at 1:45 p.m., CNA 1, QMA 2 and CNA 3 transferred Resident D from her wheelchair to the bed by using a mechanical lift. Resident D was provided incontinent care and had a large pink bruise on her left hip. The resident had a below the knee amputation and had an above the knee immobilizer on the left knee and thigh. The resident attempted to talk but was not understandable. During an interview with Resident D's family, on 4/13/26 at 2:26 p.m., they indicated they were notified on 3/27/26 at 5:45 a.m. that Resident D was being sent to the emergency room because she fell out of the mechanical lift. The family member indicated the Administrator reported to her that on 3/27/26 CNA 4 had transferred Resident D alone with the mechanical lift and she fell out of the mechanical lift. The emergency room did not do any x-rays of the resident's left leg on 3/27/26 because she was complaining of head, neck and back pain. Resident D began complaining of left leg pain on 4/6/26 and was found to have a fracture. The doctor said Resident D could not have surgery on the fracture because she would have to have more of her leg amputated. Resident D did not want to have more of her leg amputated and decided to let it heal on its own. During an interview with CNA 4, on 4/14/26 at 6:23 a.m., the CNA indicated she was the CNA that transferred Resident D alone on 3/27/26 when the resident fell out of the mechanical lift. The CNA was getting Resident D up for dialysis and used the mechanical lift and the resident leaned forward and fell out of the lift on her face. CNA 4 indicated she was trained on the proper technique of having two staff when utilizing a mechanical lift. During an interview with LPN 5 on 4/14/26 at 6:38 a.m., the LPN indicated he was the nurse for Resident D on 3/27/26 when she fell out of the mechanical lift. LPN 5 was not aware that CNA 4 was transferring the resident by herself until after it happened. When the LPN got to Resident D's room, she was lying on her left side and was profusely (large amount) bleeding from her forehead. LPN 5 indicated him and three other staff transferred her to the stretcher and Resident D was sent to the emergency room. At the time of the transfer Resident D was complaining of pain everywhere. The guidelines for usage of a mechanical lift provided by the Administrator, on 4/14/26 at 10:47 a.m., indicated two staff members were required when using a mechanical lift. When utilizing a mechanical lift, one person should always maintain control of the resident while the second person operates the mechanical lift. The current mechanical lift manufacturing guidelines for the Hoyer HPL700 indicated the maximum weight limit for the lift used was 700 pounds, with a minimum height of 57.75 inches and maximum height of 81 inches. Training videos for the mechanical lift indicated two staff were to be present during the use of the lift (one to stabilize the resident and one to operate the controls) with transfers. This deficient practice was corrected on 3/30/26, 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, QMAs and CNAs to ensure mechanical lift safety. All Licensed Nurses, CNAs and QMAs had to complete a competency demonstration with the Director of Nursing of the operation of a mechanical lift safely before they could work the floor. A safety audit was completed for all residents who required a mechanical lift to ensure the lift was appropriate for the resident. All mechanical lifts were inspected to ensure they were in safe working order. The facility continues (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	ongoing audits and observations of mechanical lift transfers. This citation relates to Intake 2966686. 410 IAC (Indiana Administrative Code) 3.1-45(a)(1)