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	01/16/2026

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, the facility failed to ensure residents' call lights were with in reach for 2 of 2 residents reviewed for accommodation of needs (Resident 14 and Resident 69). Findings include:1.During an observation on 1/13/2026 11:01 a.m., Resident 14 was sitting in her room in a geriatric chair, the resident's touch pad call light was hanging on the wall behind her bed, not within reach of the resident. The roommates call light was activated. During an interview with the Staffing Coordinator on 1/13/26 at 11:15 a.m., the Staffing Coordinator indicated whoever brought Resident 14 back to her room was responsible to provide her with her call light. The Staffing Coordinator provided Resident 14 with her touch pad call light. Review of the clinical record of Resident 14 on 1/16/26 at 11:15 a.m., indicated the resident's diagnoses included, but were not limited to, chronic heart failure, lack of coordination, unsteadiness on feet, chronic obstructive pulmonary disease, major depressive disorder and osteoarthritis. The care plan for Resident 14, dated 9/26/2020 (target date 2/11/26), indicated the resident required assistance with activities of daily living. The interventions included, but were not limited to, keep call light in reach. The care plan for Resident 14, dated 11/3/23, indicated the resident was at risk for falls. The interventions included, but were not limited to, keep call light in reach. The annual Minimum Data Set (MDS) assessment for Resident 14, dated 11/8/25, indicated the resident was severely impaired for daily decision making. 2.During an observation and interview on 1/13/2026 at 11:27 a.m., Resident 69 was lying in bed and indicated she could not find her call light and requested help. The resident's call light was on the floor behind her bed. The resident indicated this was not the first time she was unable to find her call light. The roommates call light was activated. CNA 3 came into the resident's room and provided Resident 69 with her call light. Review of the clinical record of Resident 69 on 1/16/26 at 11:45 a.m., indicated the resident's diagnoses included, but were not limited to, respiratory failure, chronic kidney disease, weakness, heart failure, difficulty walking, diabetes, anxiety and unsteadiness on feet. The care plan for Resident 69, dated 3/18/25, indicated the resident was at risk for falls due to weakness. The interventions included, but were not limited to, keep call light in reach. The quarterly MDS assessment for Resident 69, dated 10/19/25, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The call light policy provided by the Executive Director on 1/16/26 at 9:45 a.m., indicated the facility would ensure that the call light was accessible to residents. 3.1-(v)(1)

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to follow a physician's order for humidified oxygen for 1 of 2 residents reviewed for respiratory care. (Resident 13) Findings include:The clinical record for Resident 13 was reviewed on 01/14/2026 at 10:31 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), mild intermittent asthma, and anxiety.The Annual Minimum Data Set (MDS) assessment, dated 1/2/26, indicated Resident 13 was cognitively intact.During an observation and interview with Resident 13 on 1/13/26 at 11:13 a.m., the resident indicated they were on oxygen at home. Oxygen was on the resident at 1 L/min (liter per minute) with no humidified oxygen hooked up to the oxygen tank.Resident 13 had a physician's order, dated 1/7/26, that indicated O2 (oxygen) at 1 to 2 L/min (liters per minute) via nasal cannula as needed for shortness of breath and to change the humidifier bottle once weekly, on Tuesday, during the day shift and as needed.The January 2026 Medication Administration Record (MAR) indicated the resident's humidifier bottle was changed on 1/13/26.During an observation and interview with Resident 13 on 1/14/25 at 12:28 p.m., no humidity bottle was hooked up to the oxygen tank. Resident 13 indicated they usually have it on their oxygen tank at home and wondered why it was not on the tank in the facility.During an observation and interview with Qualified Medication Assistant (QMA) 2 and Resident 13 on 1/14/26 at 1:36 p.m., QMA 2 verified that no humidity was applied to Resident 13's oxygen tank. QMA 2 then applied humidity bottle to the oxygen tank. Resident 13 did not decline or voice any refusal of the oxygen humidity being applied. During an interview with Resident 13 on 1/15/26 at 1:02 p.m., they indicated they did not have a problem with humidity bottle on their oxygen tank, had it on at home, wondered why they did not have it here, but did not question it. Resident 13 indicated yesterday, 1/14/26, one of the nurses came in to their room, noticed they did not have humidity bottle to their oxygen, and put it on right then. Resident 13 indicated that was all they had heard about the humidity bottle needing to be on the oxygen tank. A plan of care, dated 1/13/26, indicated Resident 13 was at risk for respiratory distress related to asthma and copd diagnosis. The interventions included, but were not limited to, administer O2 (Oxygen) per MD (Physician) order. An Oxygen Administration Policy was provided by the Executive Director (ED) on 1/16/26 at 9:45 a.m. It indicated .Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders for oxygen administration.3. Assemble the equipment and supplies as needed.Steps in the procedure: 12. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar.14. Periodically re-check the water level in humidifying jar. Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: .1. Date and time the procedure was performed. 8. If the resident refused the procedure, the reason (s) why and the intervention taken.Reporting: 1. Notify the supervisor if the resident refuses the procedure. 3.1-47(6)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a newly admitted resident had his pain medication available as ordered by the physician for 1 of 1 residents reviewed for pain (Resident 66). Finding include:During an interview with Resident 66 on 1/13/2026 at 11:44 a.m., the resident indicated he had been without his tramadol pain medication since he was admitted to the facility on [DATE]. The nurses told him that it had something to do with the prescription not being signed. The resident indicated his pain level had been a 3 out of a 1 to 10 pain scare (one being no pain and 10 being the worst pain). The resident indicated his left hip was sore because he had broke it and had surgery. During an observation and interview with Resident 66 on 1/14/2026 at 1:01 p.m., the resident indicated he had been requesting his tramadol pain medication every day since admission because he needed to help him walk with his walker. The resident indicated not having his tramadol pain medication available prevented him from walking and it slowed him down for sure. During an observation the resident had a rolling walker beside his bed. During an interview with Resident 66 on 1/15/2026 at 10:43 a.m., the resident indicated he did receive Tylenol for pain, but it did not help at all. The nurses kept telling him the facility did not have tramadol. Review of the clinical record of Resident 66 on 1/14/2026 at 10:54 a.m., indicated the resident's diagnoses included, but were not limited to, orthopedic aftercare, left fracture, diabetes, hypertension, contracture of left hand and osteoarthritis. The resident was admitted to the facility on [DATE]. The hospital note for Resident 66, dated 12/2/25, indicated the resident had a left hip fracture and required a open reduction and internal fixation surgery on 12/4/25. The progress note for Resident 66, dated 1/10/26 at 6:30 p.m., indicated the resident was admitted from another long term care facility. The resident was alert and oriented and was able to make his needs known. The physician's order for Resident 66, dated 1/10/26, indicated the resident was ordered tramadol 50 milligrams (mg) every 6 hours as needed for pain. The care plan for Resident 66, dated 1/10/26, indicated the resident was at increased risk in pain/discomfort or had current pain. The interventions included, but were not limited to, administer pain medication as ordered. During an interview with the Director Of Nursing (DON) on 1/14/26 at 12:45 p.m., the DON indicated the facility had tramadol available in the automated dispensing cabinet. The resident was admitted to the facility with an invalid prescription for tramadol. The nurse attempted to call the after hour company twice to get the correct prescription and they never returned the nurses calls. The Nurse Practitioner (NP) does not have privileges and authority yet to sign prescriptions. The nurse could have called the DON or the Administrator and they would have contacted the Medical Director to sign the prescription, but she did not. The DON found about the situation on 1/13/26 and got the prescription signed. The pain policy provided by the Executive Director (ED) on 1/16/26 at 9:45 a.m., indicated the provider would order appropriate medication interventions to address the individual's pain. The automated medication dispensing machine policy provided by the ED on 1/16/26 at 9:45 a.m., indicated the nursing staff would use the machine for to distribute medications for emergency, first dose and other situations where the medication was not readily available from the pharmacy. No medications would be removed from the machine without a valid prescription or upon a physician order. 3.1-37(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to monitor valproic acid levels for a resident with a diagnosis of seizures and receiving Divalproex Sodium for 1 of 5 residents reviewed for unnecessary medications. (Resident 5) Findings include: The clinical record for Resident 5 was reviewed on 1/14/2026 at 11:10 a.m. The resident's diagnoses included, but were not limited to, epilepsy (chronic brain disorder causing recurring seizures), muscle weakness, and chronic kidney disease.The Annual Minimum Data Set (MDS) assessment, dated 9/20/25, indicated Resident 5 was moderately cognitively impaired for daily decision making, had seizure disorder, and received anticonvulsants.During a review of Resident 5's current medication orders on 1/15/26 at 10:51 a.m., Resident 5 was ordered Divalproex Sodium Oral Tablet Delayed Release 500 MG (Divalproex Sodium), staff were to administer 1 tablet by mouth two times a day for seizure with a start date of 11/10/25.Resident 5's Electronic Health Record (EHR) indicated no valproic acid levels were drawn or monitored since January 2025.A plan of care, dated 1/9/26, indicated Resident 5 was at risk for seizure activity related to seizure disorder. The interventions included, but were not limited to, administer medication as directed and follow pharmaceutical recommendations and medication levels as ordered per physician.During an interview with the Director of Nursing (DON) on 1/15/26 at 2:00 p.m., they indicated they could not find where Resident 5 had valproic acid levels drawn in the last year.During an interview with Nurse Practitioner (NP) on 1/16/26 at 10:14 a.m. they indicated there was no order for a valproic acid level for Resident 5 since taking over her care in May 2025 and now there was an order for maintenance. The NP indicated they normally have an order for valproic acid levels to be drawn routinely, it was standard practice. The NP indicated it was brought to her attention yesterday and orders were put in to monitor valproic acid levels every six months ongoing.During an interview with the DON on 1/16/26 at 10:40 a.m., they indicated they follow what the physician's orders in regards to lab orders and monitoring.The Medication Utilization and Prescribing Policy was provided by the Executive Director (ED) on 1/16/26 at 11:12 a.m. It indicated .Monitoring: 1. The staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to determine if the medication and doses are still relevant and are not causing undesired complications.The Seizures and Epilepsy Policy was provided by the Executive Director (ED) on 1/16/26 at 11:12 a.m. It indicated .Monitoring: 2. The physician will monitor antiepileptic medication blood levels periodically.According to the Dr. Oracle Medical Advisory Board & Editors, 2025, valproate levels should be checked every 6 months in patients taking divalproex sodium (Depakote) for seizures, as recommended by the most recent and highest quality study. The monitoring of valproate levels is crucial to maintain therapeutic efficacy while minimizing adverse effects. 3.1-48(a)(3)