STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castleton Health Care Center	7630 E 86th St Indianapolis, IN 46256

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, interview, and record review, the facility failed to perform post fall assessments timely, obtain blood sugar readings and administer insulin as ordered by the physician, and timely update physician's orders for a diabetic foot ulcer for 1 of 3 residents reviewed for falls and 2 of 3 residents reviewed for medication administration. (Resident B, Resident F, and Resident H)Findings include: 1. The clinical record for Resident B was reviewed on 7/16/25 at 11:00 a.m. The diagnoses included, but were not limited to, encephalopathy (brain dysfunction) and heart failure. An Annual Minimum Data Set (MDS) assessment, completed 3/14/25, indicated Resident B was cognitively impaired. A nursing progress note, dated 3/11/25 at 11:44 p.m., indicated Resident B had sustained a fall. “Resident had a fall this shift in bedroom, CNA [Certified Nurse Aide] was doing her rounds when resident was found laying on his belly with right foot tangled in sheet. When asked [what happened] resident stated he was trying to get something off the floor. Floor was clear. CNA had last seen resident 15 minutes prior to fall to change resident. Neuro [neurological] sheet form completed. No injuries noted at this time. PRN [as needed] pain med [medication] was given. Family, NP [Nurse Practitioner], and DON [Director of Nursing] notified.” An incident report, dated 3/11/25, indicated Resident B had sustained a fall in his bedroom and no injuries were noted. The incident report indicated it was “Not part of the medical record”. A nursing progress note, dated 3/13/25 at 8:32 a.m., indicated Resident B had sustained a fall. “Resident [Resident B] had fall 3/13/25 at approx [approximately] 1408 [2:08 p.m.], observed resident on the floor with blanket on top of him. Resident stated 'that he was trying to find something on the floor'. Used Hoyer [a mechanical lift] to transfer resident from the floor [to] the wheelchair. No noted injuries, resident intervention was to move bed against wall, all parties aware of resident updates, will continue to observe resident.” An incident report, dated 3/12/25 at 2:08 p.m., indicated Resident B’s Representative arrived and yelled for help. Staff ran to the room and found the resident on the floor with a blanket on top of him. No injuries were noted. The incident report indicated it was “Not part of the medical record”. The clinical record did not contain a nursing progress note indicating a fall had occurred on 3/12/25 and did not include a post fall assessment after the fall sustained on 3/11/25 or 3/12/25. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 7/17/25 at 1:50 p.m., she indicated the second fall Resident B sustained was on 3/12/25, and not 3/13/25. The DON indicated a fall risk evaluation is considered the post fall assessment within the electronic health record and did not know why a fall risk evaluation was not completed after either fall on 3/11/25 or 3/12/25. On 7/17/25 at 1:50 p.m., the DON provided the current Fall Management Program Policy which indicated “…IV. Post-Fall A. Following a resident’s fall, the licensed nurse will complete an incident report and a Post Fall Assessment and Investigation within 24 hours or as soon as practicable. B. The Licensed Nurse will review the circumstances of the fall, review the plan of care, implement new interventions as appropriate and revise the plan as indicated…” 2a. The clinical record for Resident H was reviewed on 7/16/25 at 2:10 p.m. The diagnoses included, but were not limited to, diabetes with foot ulcer, repeated falls, and dementia. An admission MDS assessment, completed 5/8/25, indicated he was severely cognitively impaired. He required substantial assistance with bathing, lower body dressing, and in donning and doffing footwear. He received insulin injections daily. A physician’s order, dated 6/10/25, indicated he was to have Hydrogel (type of wound treatment) applied to his left foot wound topically one time a day every Monday, Wednesday, and Friday for wound care. A Podiatry progress note, dated 6/12/25, indicated his left fourth toe had been treated with Gentian violet (type of wound medication), iodosorb (type of wound dressing) and covered with gauze and loose Coban (type of wound dressing). The dressing was to be changed weekly at the podiatry visits. A Podiatry progress note, dated 6/26/25, indicated his left fourth toe had been treated with collagen with silver (type of wound dressing) and covered with gauze and loose Coban (type of wound dressing). The dressing was to be changed weekly at the podiatry visits A care plan, initiated 7/1/25, indicated Resident H had a diabetic ulcer on his left fourth toe. The goal was for him to have blood sugar levels controlled and for him to have no complications related to the ulcer. The interventions included, but were not limited to, determine and treat cause: poor fitting shoes, poor blood sugar control, pressure area, and/or infections, monitor blood sugar levels, and monitor pressure areas for color, sensation, and temperature. A care plan, initiated 7/1/25, indicated Resident H needed assistance with his activities of daily Living (ADL) care due to his dementia and history of falls. The goal was for him to maintain current functioning. The interventions included, but were not limited to, observing skin for redness, open areas, scratches, cuts, bruises and report changes to the nurse. Staff were to provide assistance with dressing and make sure shoes were comfortable and not slippery. A Podiatry Progress note, dated 7/3/25, indicated Resident H had wounds to his bilateral lower extremities. His left fourth toe had a diabetic ulcer which measured 0.4 centimeters (cm) in length, 0.3 cm in width, and was 0.1 cm in depth. There was no drainage present at the wound site. The wound was cleansed with soap and water, and moisturizing cream was applied. The wound was treated with an Iodine based product and wrapped with a soft gauze roll and covered with a stretch netting. The dressing was to be changed weekly. The dressing was to be kept dry and intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Podiatry Progress note, dated 7/10/25, indicated Resident H’s left fourth toe diabetic ulcer had healed, measuring zero cm in length, width, and depth. The area was cleansed with soap and water. No dressing was applied to Resident H’s left foot. The clinical record did not contain a physician’s order for the left foot dressing to be changed weekly at the podiatry visit. The June 2025 and July 2025 Medication Administration Record (MAR) indicated that Hydrogel had been applied topically to the left foot on 6/23/25, 6/27/25, 6/30/25, 7/2/25, 7/4/25, 7/9/25, 7/11/25, and 7/16/25. During an interview on 7/17/25 at 10:18 a.m., Licensed Practical Nurse (LPN) 2 indicated the nursing staff did not change the dressings on Resident H’s feet. The dressings were changed weekly at his wound appointments. The dressings were only to be reinforced or changed if they were dislodged. On 7/17/25 at 11:25 a.m., Resident H’s left foot was observed with LPN 2. LPN 2 removed Resident H’s left sock, and a large amount of dried skin flakes fell from the sock onto the floor. LPN 2 questioned Resident H where his dressing was. Resident H indicated his wound was healed. His left foot had no dressing present on it. His toes were painted a purple color, which LPN 2 indicated was from being treated with gentian violet. There was dried skin, and a whitish substance caked between his toes. There was a piece of dried skin hanging from the bottom of his foot just above his heel. The dried skin was shaped like a bowl and contained dried skin flakes. The ankle and top of the foot had dried, cracked skin present. LPN indicated Resident H’s foot was dry and needed to be soaked. She was unsure how long the flap of dried skin had been present on his foot or what had caused it. On 7/18/25 at 11:38 a.m., the DON provided a Skin Monitoring Comprehensive CNA Shower Review, dated 7/11/25, that indicated Resident H had extremely dry skin to his left foot. The right foot was wrapped with treatment. The area was washed, and personal lotion was applied per Resident H’s request. The dry skin was discussed with the Nurse Practitioner (NP). During an interview on 7/18/25 at 11:38 a.m., the DON indicated the wound nurse had observed Resident H’s left foot, on 7/11/25, and had informed the NP about his dry skin. The NP had not written any new orders but had told the wound nurse to continue to use house lotion for the dry skin. There was no documentation that lotion had been applied to Resident H’s left foot. On 7/17/25 at 2:30 p.m., the DON provided the current Foot- Care of policy which indicated “…Purpose To provide hygienic care of the feet, to prevent skin breakdown or infections and to promote comfort…I. Foot care is provided to residents as a component of a resident’s hygienic program. II. Residents with impaired peripheral circulation such as diabetes, vascular, or arterial disease will have their feet inspected during scheduled treatments, hygiene i.e. Bathing schedule and adl’s such as dressing, and as needed…” 2b. A physician’s order, dated 6/10/25, indicated Resident H was to receive Lantus Solostar (long-acting insulin) 30 units subcutaneously once daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician’s order, dated 6/18/25, indicated to check Resident H’s blood sugar before meals and at bedtime. The June 2025 and July 2025 MAR indicated that Resident H did not receive his Lantus Solostar insulin on the following days: 6/17/25 - blood sugar 107; not given due to vital signs outside parameters, 6/19/25 - blood sugar 129; not given due to vital signs outside parameters, 7/4/25 - blood sugar 87; not given due to vital signs outside parameters, and 7/9/25 - blood sugar 73; not given due to vital signs outside parameters. The clinical record did not contain documentation that the physician had been notified that the Lantus Solostar had been held due to blood sugar readings. The June 2025 and July 2025 MAR indicated Resident H’s blood sugar checks had been completed before meals and at bedtime, however, only the 9:00 a.m. blood sugar reading was recorded in the clinical record. During an interview on 7/17/25 at 10:18 a.m., LPN 2 indicated she did not believe Resident H had hold orders for his insulin. The standard was to hold insulin if blood sugar readings were below 70 and call the physician. During an interview on 7/17/25 at 3:10 p.m., the DON indicated there were no additional blood sugar readings and documentation of notification of the physician when the insulin was held in the clinical record. 3. The clinical record for Resident F was reviewed on 7/16/25 at 2:20 p.m. The diagnoses included, but were not limited to, diabetes. A physician’s order, dated 3/27/25, indicated Resident F was to have their blood sugar checked every six hours and as needed. The physician was to be notified if blood sugar was less than 70 or greater than 350. A physician’s order, dated 3/27/25, indicated she was to receive insulin lispro (short acting insulin) subcutaneously every six hours per sliding scale: blood sugar (BS) of 150 to 200 give 2 units, 201 to 250 give 4 units, 251 to 300 give 6 units, 301 to 350 give 8 units, and 351 to 400 give 10 units. A care plan, last revised on 4/3/25, indicated Resident F had diabetes. The goal was for her to have no complications related to diabetes. The interventions included, but were not limited to, administering diabetes medications as ordered by the doctor. The July 2025 MAR did not contain blood sugar readings or insulin administration documentation on the following days and times: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/1/25 at 5:00 a.m., 7/2/25 at 5:00 a.m., 7/3/25 at 5:00 a.m., 7/6/25 at 5:00 a.m., 7/8/25 at 5:00 a.m. 7/11/25 at 5:00 a.m., and 7/13/25 at 5:00 a.m. and 5:00 p.m. During an interview on 7/17/25 at 3:10 p.m., the DON indicated the blood sugar and insulin administered should have been recorded on the MAR. On 7/18/25 at 12:41 p.m., the DON provided the current Medication Administration Policy that indicated “…VI. Tests and taking of vital signs, upon which administration of medication or treatments are conditioned, may be performed as required by state law, and the results recorded. VII. When administration of the drug is dependent upon vital signs or testing, the vital signs/ testing will be completed prior to administration of the medication and recorded in the medical record [i.e., BP, pulse, finger stick blood glucose monitoring etc .] … Procedure…XVI. The Licensed Nurse will chart the drug, time administered and initial his/her name with each medication administration…XVII. Holding Medications A. Whenever a medication is held for any reason, the Licensed Nurse will initial the appropriate area on the MAR and circle his/ her initials. The Licensed Nurse will document the reason the medication was held on the back of the MAR…” This citation relates to Complaint 1258043 and Complaint 1258045. 3.1-37(a)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review, the facility failed to obtain laboratory services timely for 1 of 3 residents reviewed for falls. (Resident B)Findings include: The clinical record for Resident B was reviewed on 7/16/25 at 11:00 a.m. The diagnoses included, but were not limited to, encephalopathy (brain dysfunction) and heart failure. An Annual Minimum Data Set (MDS) assessment, completed 3/14/25, indicated Resident B was cognitively impaired. A progress note, dated 3/16/25 at 5:53 a.m., indicated Resident B was experiencing signs and symptoms of confusion and restlessness. A progress note, dated 3/16/25 at 6:31 a.m. , indicated nursing staff had received new orders for STAT (immediate) laboratory testing from the on-call Nurse Practitioner/Physician. Laboratory testing ordered included a complete blood count (CBC) and complete metabolic panel (CMP). A physician's order, initiated on 3/16/25, indicated to obtain a CBC and CMP STAT for altered mental status. The clinical record for Resident B did not contain laboratory results for the CBC and CMP ordered on 3/16/25. During an interview on 7/17/25 at 2:35 p.m., the Director of Nursing (DON) indicated the laboratory testing, ordered on 3/16/25, for Resident B was never drawn.A Laboratory, Diagnostic and Radiology Services Policy, last revised 06/2020, was provided by the DON on 7/17/25 at 3:25 p.m. It indicated .I. Laboratory, diagnostic and radiology services will be coordinated pursuant to an order by a physician, physician assistant, nurse practitioner or clinical nurse specialist in accordance with the scope of practice under state law.II. The Facility is responsible for the quality and timeliness of services provided by the laboratory, diagnostic or radiology provider.This citation relates to Complaint 1258045. 3.1-49(a)

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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. Based on interview and record review, the facility failed to ensure a resident's fall, notification of physician of the fall, and notification of the responsible party of the fall were documented in the clinical record for 1 of 3 residents reviewed for falls (Resident H).Findings include: The clinical record for Resident H was reviewed on 7/16/25 at 2:10 p.m. The diagnoses included, but were not limited to, diabetes with foot ulcer, repeated falls, and dementia.An admission Minimum Data Set (MDS) assessment, completed 5/8/25, indicated he was severely cognitively impaired. He required substantial assistance with bathing, lower body dressing, and donning and doffing footwear. A care plan, last revised 7/1/25, indicated Resident H had an actual fall with minor injury due to poor balance. The goal was for him to resume usual activities without further incident. The interventions included, but were not limited to, monitor, document and report as needed for 72-hours to the physician regarding signs and symptoms of pain, bruises, and changes in mental status. On 7/17/25 at 1:50 p.m., the Director of Nursing (DON) provided a Fall Incident report, dated 7/8/25, that identified the report as not a part of the medical record. The incident report indicated Registered Nurse (RN) 3 had prepared the report on 7/8/25 at 5:00 p.m. Resident H had fallen forward out of the wheelchair onto his knees. There were no injuries noted, and the resident did not hit his head. Resident H reported that he was reaching for a fork that had dropped and lost his grip. The fall was not witnessed. The immediate action taken was that staff assisted the resident to his wheelchair. His mental status was alert and oriented to person, place, and time. The predisposing physiological factor was weakness/ fainting. The family member had been notified on 7/8/25 at 5:00 p.m., and the DON had been notified on 7/9/25 at 2:15 p.m.A Health Status Note, dated 7/9/25 at 2:15 p.m., written by RN 3, indicated he was informed by the unit manager that Resident H had an unwitnessed fall yesterday. The resident said he was sitting in his wheelchair and reached for a fork he had dropped and lost the grip he had on the arm of the wheelchair. The clinical record did not contain documentation on 7/8/25 that Resident H had fallen or that the physician and/or family had been notified of the fall. During an interview on 7/17/25 at 2:30 p.m., the DON indicated the fall on 7/8/25 had been documented in risk management. The documentation in risk management can be used as a progress note. She normally would cut and paste the notes from risk management into the progress notes in the clinical record. It was best practice to document falls in the resident's clinical record. On 7/17/25 at 2:30 p.m., the DON provided the current Response to Falls Policy that indicated .Documentation. A. Document notification of physician and responsible party. B. Document notification of physician and responsible party. C. Complete an incident report and a detailed progress note. G. Document residents condition in the medical record every shift for 72 hours .This citation relates to Complaint 1258043 and Complaint 1258045. 3. 1-50(a)(1)3.1-50(a)(2)