

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2025
NAME OF PROVIDER OR SUPPLIER Castleton Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86th St Indianapolis, IN 46256	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse by a resident-to-resident altercation for 2 of 2 residents reviewed for abuse. (Residents CC and Resident J) Findings include: The clinical record for Resident CC was reviewed on 8/5/25 at 10:00 a.m. The diagnoses included, but were not limited to, paranoid schizophrenia. A care plan, dated 3/30/25, indicated Resident CC had a behavior of being obsessive compulsive. The interventions included, but were not limited to, Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. A care plan, dated 4/3/25, indicated the resident had difficulties with changes. The clinical record for Resident J was reviewed on 8/5/25 at 10:15 a. m. The diagnoses included, but were not limited to, schizoaffective disorder and bipolar disorder. A care plan, dated 7/9/25 with revision date of 7/11/25, indicated Resident J had anxiety disorder. A reportable incident to the Indiana Department of Health, dated 7/9/25, indicated a resident-to-resident altercation had occurred between Resident CC and Resident J in the dining room. Both residents were cognitively intact. Resident CC hit Resident J on the upper right chest and upper lip. Resident CC believed Resident J was sitting in his chair in the dining room. The follow up to the incident indicated, .[Resident CC] became upset when [Resident J] sat down at the table in the dining room that [Resident CC] considered his table. [Resident CC] tried to get [Resident J] to move and when he did not move [Resident CC] struck [Resident J] on the chest and upper lip. [Resident J] did not reciprocate. Staff immediately intervened and separated both residents. Interview conducted with both residents [Resident CC].admitted striking [Resident J] .for sitting at his table. [Resident CC] admitted that striking out was inappropriate. [Resident CC] was placed on 1:1 [one-on-one supervision] until transfer to psych [psychiatric facility], social services conducted psychosocial follow ups and subsequent transfer to psych facility.[Resident J] requested to file a report with the police department. IPD [Indianapolis Police Department] notified per social services and police came to the facility for [Resident J]'s statement. Police department reported to Director of Nursing that no arrest was going to occur as the facility was handling the situation appropriately.An incident investigation file between Resident CC and Resident J was provided by the Executive Director (ED) on 8/5/25 at 10:42 a.m. It included, but was not limited to, the following documentations: A skin assessment dated [DATE] indicated Resident J's lip and right upper chest was red. A statement written by Licensed Practical Nurse (LPN) 4, dated 7/9/25, indicated, At about 6:00 a. m. [Resident CC] was sitting at the table with [Resident J] at the dining area. [Resident CC] got upset because he thought [Resident J] was not supposed to be sitting at the table with him. [Resident CC] stated 'you are not supposed to be sitting here. This is where I sit every day. I don't want you here.' Writer [LPN 4] intervened and spoke to both men to sit together or move to another table. [Resident CC] stepped forward and punched [Resident J] with his fist at the right chest area. Writer separated both and removed the table to avoid further fight. [Resident CC] went back to [Resident J] and punched him again after being separated. A progress note for Resident CC written by the Director of Nursing (DON), dated 7/9/25, indicated resident [CC] had poor interaction with another resident [J]. This resident struck other resident on residents headphones hanging around other resident's neck/chest with a closed hand. Residents immediately separated, and nurse came to tell writer that incident had occurred, on writers [DON's] way to residents to conduct interviews and assessments for resident safety, this writer saw this resident struck the other resident in the face with a closed fist. Residents were immediately separated and this resident was placed on one on one care, this resident [Resident CC] was noted to have slight skin tear to left picky, this resident denies pain .working on referral to [psych facility] .A progress note for Resident J written by the DON, dated 7/9/25, indicated .This resident [Resident J] educated to stay separated from other resident [Resident CC] at this time. This resident was noted to have edema to upper lip following incident. An interview was conducted with the DON on 8/5/25 at 11:23 a.m. She indicated she had witnessed an altercation, on the morning of 7/9/25, between Resident J and Resident CC. That morning, she was in a resident's room providing care. During that time, LPN 4 came to the room and reported Resident CC had gotten upset about Resident J sitting at his table. Resident CC had hit Resident J with his fist in the chest area. She immediately left the resident's room and went to the dining room where Resident J and Resident CC were located. After entering the dining area, she observed Resident CC with his closed fist hit Resident J in the face. The residents were immediately separated. LPN 4 was the only staff person present at that time in the dining room when Resident CC got</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to timely report an allegation of missing funds to the Indiana Department of Health for 1 of 4 residents reviewed for misappropriation. (Resident C) Findings include: The clinical record for Resident C was reviewed on 8/4/25 at 10:00 a.m. The diagnoses included, but were not limited to, cognitive communication deficit. A Quarterly Minimum Data Set assessment, dated 7/4/25, indicated Resident C was moderately cognitively impaired. A list of grievances for the month of June and July of 2025 was provided by the Executive Director (ED) on 8/4/25 at 10:15 a.m. Resident C was not listed on the list for missing items or funds. During an interview on 8/4/25 at 2:40 p.m., Resident C's Representative indicated he brought \$80.00 into the facility and gave it to the previous Business Office Manager (BOM) over Easter weekend in April, and the money was put into a safe. He indicated the current BOM did not know where the funds were after he inquired about them later in April and was not aware of any money being held in the safe. On 8/4/25 at 3:00 p.m. an interview was conducted with the ED, she indicated she did not have any reportable incidents logged for missing funds, and if money had been missing, she would have reported it. An interview was conducted, on 8/4/25 at 3:20 p.m., with the current BOM. She indicated a meeting took place, on 7/10/25, with herself, Resident C's Representative, the Ombudsman, and the Social Services Director. The current BOM indicated Resident C's Representative made the allegation of missing funds during that meeting, afterward she notified the ED. During an interview on 8/5/25 at 12:18 p.m., the ED indicated she was on vacation for ten days around the time of the meeting held, on 7/10/25, and could not say for certain that she was notified of the alleged missing funds. She indicated if she were made aware she would report it to the Department of Health. The ED indicated, on the evening of 8/4/25, she was able to locate the missing funds for Resident C, and Resident C's Representative had been notified. On 8/5/25 at 2:05 p.m., an interview was conducted with the ED. She indicated as soon as missing funds were mentioned, it should have been reported, regardless of whether she was in the building or not. The ED indicated she would be reporting the allegation of missing funds to the Department of Health that day (8/5/25). An undated Abuse Prevention and Prohibition Program Policy was provided by the Director of Nursing on 8/5/25 at 11:25 a.m. It indicated .Reporting/Response. D. The Facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime. ii. No later than 24 hours after forming the suspicion - if the alleged violation (e.g., misappropriation of property, neglect) does not involve abuse and does not result in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman. This citation is related to Complaint 2571677. 3.1-28(c)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the disposition of a resident's Percocet (oxycodone-acetaminophen) medication was handled securely; which included ensuring staff were implementing accurate monitoring, tracking and timely destroying a not needed narcotic medication. This resulted in the facility missing 44 white tablets of 10-325 milligram tablets of Percocet medication for 1 of 4 residents reviewed for narcotic medications. (Resident L) Findings include: The clinical record for Resident L was reviewed on 8/4/25 at 1:00 p.m. The diagnoses included, but were not limited to, osteoarthritis. A physician's order, dated 5/19/25, indicated Resident L was to receive 10-325 milligrams of Percocet every six hours. A pharmacy delivery form, dated 7/14/25, indicated delivery of 56 tablets of 10-325 milligrams of Percocet for Resident L. There was a written note on the form indicated, resending yellow. A reportable incident to the Indiana Department of Health, dated 7/21/25, indicated the facility was missing a card of 44 white tablets of 10-325 milligrams of Percocet for Resident L. During change of shift, narcotics were being counted. During the count between day and night shift (leaving) ADON [Assistant Director of Nursing] asked where the card of white Percocet for the resident was. At this time meds were unaccountable for. investigation and interviews initiated. police reported. Follow up: 7/24/25 Investigation completed and thoroughly investigated. On 7/21/25, the DON [Director of Nursing] was notified of missing Percocet, who notified Executive Director [ED] and Regional Nurse Consultant [RNC]. The ADON and Executive Director went to the medication cart that housed the medication, all the medication carts were thoroughly inspected. All narcotics were counted by 2 licensed nurses and correct counts were identified. No narcotic sheet or medication found on the white card of Percocet. Resident receives Percocet 4 x [times] a day, on July 14, 2025, pharmacy sent a card of 56 white tabs [tablets]. Resident prefers using yellow Percocet and therefore after a few doses of white, the resident stated they don't work like the yellow ones. [NAME] tabs were the same dosage. The physician was notified of the inability of facility to locate the card of white Percocet., and the resident wish to only be administered the yellow Percocet. July 16, 2025, pharmacy notified and sent a new card of 56 yellow tabs. The resident was notified. During the interviews with nurses, 2 nurses recalled seeing them when she counted the white card of 44 tabs. On the morning of July 21st during the shift change from nights to days, ADON was counting narcotics and noted the white card of Percocet was not present. She queried the night nurse; her response was that the medication was not there/recalled seeing them when she counted at 11pm [11:00 p.m.]. The nurse stated she called them on Sunday counting with the evening nurse. The evening nurse on 7/20/25, stated she could not recall if white Percocet was there. The police and ombudsman, AG [Attorney General] were notified. Pharmacy notified to bill facility for white card of 56 Percocet, not resident. Nurses/QMA [Qualified Medication Aide] were suspended and will be [NAME]-serviced on control narcotic competencies. ADON was in-serviced on destruction of narcotics. The medical director was contacted by DON. Audits were conducted with residents to determine satisfaction with pain medications, effectiveness, and administered as ordered. No residents reported concerns with pain medication administration. Medication administration records reviewed for those residents that received pain medication from 7-19 through 7-20-25. No discrepancies were identified. Review of narcotic counts for any discrepancy will be reviewed during morning/clinical meeting. Identified areas narcotic count records will be reviewed 5 times weekly to include all three shifts by the Director of Nursing/designee/ADON and per Regional Nurse consultant during weekly scheduled visits to the facility. Narcotic sheets will be dated and initiated by those that review them for 6 months and until audits reflect 100 percent compliance and IDT [Intradisciplinary team] determines audits can be discontinued. Nursing staff will be educated on narcotic destruction and correct signage. Identified issues of non-compliance will result in disciplinary action. The reportable incident investigation file was provided by the ED on 8/4/25 at 11:30 a.m. It included, but was not limited to, the following documents: A witness statement by the ED, dated 7/21/25, indicated the pharmacy was notified. The pharmacy reported 56 yellow 10-325 milligrams of Percocet were delivered to the facility on 7/14/25. A statement by Licensed Practical Nurse (LPN) 1, dated 7/21/25, indicated Received call from DON. DON asked about oxycodone. I worked day/evening on Sat [Saturday] (7/19/25) and Sun [Sunday] (7/20/25) 7 a.m. - 11:00 p.m. Sat. I was on Sunset [hallway] and 1/2 of Boardwalk [hallway] when I worked. [Resident L] had cards of yellow and white. 11:00 a.m. - 11:30 p.m. I was relieved by [LPN 3] and cards were present. Sunday - day shift worked Sunset Resident still had both cards. On evening Sunday I went to Shoreline</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to ensure floors were clean as evidenced by spillage of unknown substances on the floors for 1 of 5 units and 14 of 14 residents reviewed for environment. (Shoreline Unit, Resident B, Resident C, Resident E, Resident J, Resident M, Resident N, Resident O, Resident P, Resident Q, Resident R, Resident S, Resident T, Resident U, and Resident V). Findings include: An observation was conducted, on 8/4/25 at 10:01 a.m., of the flooring by the nurse's station and Shoreline hallway. Dirt and spots of spillage of an unknown black substance were observed on the flooring in the hallway and adjacent nurse's station. During an interview on 8/4/25 at 10:35 a.m. with Resident G's Representative, he indicated the housekeeping was bad at the facility and the building was dirty. An observation was conducted, on 8/4/25 at 12:23 p.m., of the flooring by the nurse's station and the Shoreline hallway. The flooring appeared dirty with spillage of an unknown black substance. The Director of Nursing (DON) provided documentation of the Resident Council minutes on 8/5/25 at 8:45 a.m. On 7/8/25 at 2:30 p.m., the following residents were in attendance of a Resident Council meeting: Resident B, Resident C, Resident E, Resident J, Resident M, Resident N, Resident O, Resident P, Resident Q, Resident R, Resident S, Resident T, Resident U, and Resident V. The Resident Council minutes indicated old business included rooms not getting clean with it being worse on the weekends. New business included trays being left in rooms, housekeeping not cleaning on the weekend, and bathrooms not being cleaned. Resident Council meeting minutes, dated 6/10/25, indicated housekeeping concerns provided by Resident N. She indicated residents had gone a whole weekend with no one cleaning the room, and Certified Nurse Aides (CNAs) indicated it was housekeeping staff's responsibility while housekeeping staff indicated it was the CNAs responsibility. During an interview on 8/5/25 at 10:30 a.m. with the Executive Director (ED), she indicated the facility had a bad weekend with housekeeping, but her employee who worked on the floors was in the building that day. A confidential interview was conducted on 8/5/25 at 2:10 p.m. They indicated when they visited the facility a couple months ago the floors were dirty. During an interview on 8/5/25 at 3:06 p.m. with the Housekeeping Supervisor, she indicated over the past weekend there was a problem with housekeeping, but she rectified the situation. A Resident Rooms and Environment Policy, last revised 8/2020, indicated .The Facility provides residents with a safe, clean, comfortable, and homelike environment. Procedure I. Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: A. Cleanliness and order. This citation related to complaint 2574380.3.1-19(f)(5)</p>		