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	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castleton Health Care Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure residents were respected and their dignity was maintained for 15 of 71 residents reviewed for resident rights (Residents' B, C, D, E, F, G, H, J, K, N, Q, T, V, FF, and ZZ).Findings include: 1. The clinical record for Resident V was reviewed on 9/18/25 at 9:30 a. m. The diagnoses for Resident V included, but were not limited to, kidney disease. An Annual 7/18/25 Minimum Data Set (MDS) assessment indicated Resident V was cognitively intact. An interview was conducted with Resident V on 9/18/25 at 9:47 a.m. She indicated first shift (day shift) Certified Nurse Aides (CNAs) were rude, sarcastic and frequently on their cell phones during care. She had been in the mechanical lift transferring to her wheelchair, and the CNA put her phone on speaker to speak to someone. 2. The clinical record for Resident ZZ was reviewed on 9/18/25 at 9:30 a.m. The diagnoses for Resident ZZ included, but were not limited to, anxiety disorder. A Quarterly MDS assessment, dated 8/20/25, indicated Resident ZZ was cognitively intact. During an interview with Resident ZZ on 9/18/25 at 1:18 p.m., he indicated the CNA staff were rude, disrespectful, and had bad attitudes. 3. The clinical record for Resident T was reviewed on 9/18/25 at 9:30 a.m. The diagnoses for Resident T included, but were not limited to, obstructive and reflux uropathy (any condition that affects urinary tract, kidneys and bladder). A Quarterly MDS assessment, dated 8/20/25, indicated Resident T was cognitively intact. An interview was conducted with Resident T on 9/18/25 at 9:25 a.m. She indicated Licensed Practical Nurse (LPN) 20 was rude and argumentative. LPN 20 will slam doors when she gets mad. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. A resident council meeting was conducted on 9/18/25 at 10:30 a.m. The attendees were the following: Residents' B, C, D, E, F, G, H, J, K, Q, and V. During the council meeting, the council indicated the staff were “rude, arrogant, and dismissive” toward the residents. The staff often times were on their cell phones during care. The council felt like they were treated like children. The staff speak in a tone as “do what we say and do it on our time not the residents' time. The residents were pushed to their rooms and forgotten. There were long delays in responding to call lights. Staff don't answer them. There were times, the residents would go to sleep with their call lights on and wake up to the call light still on. The council complained, but do not see any change in the mannerisms of the staff. 5. The clinical record for Resident FF was reviewed on 9/17/25 at 11:56 a.m. The resident's diagnosis included, but were not limited to, diabetes and delusional disorder. A Quarterly MDS assessment, completed 8/15/25, indicated he was cognitively intact. He rejected care four to six times during the look back period and displayed behaviors not directed at others. During an interview on 9/17/25 at 11:56 a.m., Resident FF indicated some of the CNAs were rude and loud mouthed and would call him out of his name at times. Some of the staff refused to heat up food items for him. 6. The clinical record for Resident Q was reviewed on 9/18/25 at 10:00 a.m. His diagnoses included, but were not limited to, Parkinson's disease. The 8/10/25 Quarterly MDS assessment indicated he was moderately cognitively impaired. An interview and observation were conducted with Resident Q on 9/18/25 at 10:05 a.m. He indicated the staff in the facility did not treat him with respect and dignity. He could be in the hallway and say Hey nurse, to the staff, and they just ignored you and acted like you didn't say anything. It took 45 minutes for his call light to be answered. It's embarrassing to have to have someone wipe me. He'd always been independent. Now he just went to the restroom by himself. Perhaps he wasn't supposed to, but that's what happened, because they don't come. Staff left him in a soiled brief all morning about three weeks ago. He and the bed were soaked. The staff said they had other patients, but they're just in the hallway bull sh***** and laughing. An interview was conducted with Resident Q on 9/18/25 at 10:03 a.m. He indicated the staff limited him to two cups of coffee a day. An anonymous interview was conducted with a staff member. They indicated if a resident asked for coffee on the evening shift, They ain't gonna get nothin' in the evening time. They don't give 'em (expletive.) 7. The clinical record for Resident N was reviewed on 9/17/25 at 12:30 p.m. Her diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic kidney disease, heart failure, and arthritis. The 8/29/25 Quarterly MDS assessment indicated she was moderately cognitively impaired. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Resident N on 9/17/25 at 12:18 p.m. She indicated staff were rough during care at times. She had arthritis in her legs and you can't just move me too quickly. It hurt and sometimes she complained. Staff would say they were getting it done. They acted like they were in a rush. It hurt her physically and mentally. She stated, I don't feel like they have to be that rough. An interview was conducted with the Executive Director (ED), Director of Nursing (DON), and the Nurse Consultant (NC) on 9/23/25 at 2:53 p.m. The ED indicated she expected the residents to be treated respectfully. A Resident Rights Quality of Life policy was provided by the ED on 9/22/25 at 2:46 p.m. It indicated, “Purpose. To ensure that all residents are treated with the level of dignity they are entitled to while residing at the Facility. Policy. Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect and individuality…VII. Facility Staff speaks respectfully to residents at all times, including addressing the resident by his or her name of choice…XII. Demeaning practices and standards of care that compromise dignity are prohibited…” A resident rights policy was provided by the ED on 9/22/25 at 2:46 p.m. It indicated, “…Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of resident's rights…” This citation relates to Intakes 2605799 and 2613777. 3.1-3(t)

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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 a resident's call light was within reach for 1 of 2 residents reviewed for call devices in reach. (Resident N)Findings include:The clinical record for Resident N was reviewed on 9/17/25 at 12:30 p.m. Her diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic kidney disease, heart failure, and arthritis. The ADL (activities of daily living) care plan, revised 8/18/25, indicated he had an ADL self-care performance deficit related to impaired balance, limited mobility, pain, and shortness of breath, and she would refuse to get out of bed. An intervention was to encourage her to use bell to call for assistance. The 8/29/25 Quarterly MDS (Minimum Data Set) assessment indicated she was moderately cognitively impaired. An observation and interview were conducted with Resident N in her room on 9/17/25 at 12:18 p.m. She was lying in bed. Her call light cord was tied around the right side rail, hanging down the right side of her bed, eight inches from the floor. Resident N had a wooden stick, one inch wide, one and half feet long on her bedside table in front of her. She used it to attempt to reach her call light, but she was unsuccessful. She indicated staff were in the room about an hour and a half earlier, but they didn't adjust her call light to be within reach. She stated, Most of the time I can't reach my call light. I don't suffer too much [sic] not being able to reach it. I take my stick and start beating on the table, and they can hear me, and then they come. She indicated she couldn't get her hand around to reach the call light cord, and she couldn't turn over to reach the light. Resident N again tried to reach her call light cord, but she couldn't. She stated, I can't get it in my hand and do anything. When she soiled her brief, she hit the bedside table or side rail with her wooden stick to get staff's attention. Resident N demonstrated this at this time. An observation and interview with Resident N were conducted on 9/17/25 at 1:55 p.m. She was lying in bed, eating her lunch. No one else was in the room at this time. Her call light remained in the same position, wrapped around the right side rail of her bed, hanging down, eight inches from the floor. Resident N indicated she wasn't sure who brought her lunch tray to her, but they did not ensure her call light was in reach. An observation of Resident N and interview with UM (Unit Manager) 6 was conducted on 9/17/25 at 1:57 p.m. UM 6 untangled her call light from the side rail and placed it within reach of Resident N. UM 6 indicated her call light should always be within her reach, and they may need to get a clip for the call light or a different type of call light. The Use of Call Light policy was provided by NC (Nurse Consultant) 1 on 9/19/25 at 10:54 a.m. It indicated, It is the policy of this home to ensure residents have a call light within reach that they are physically able to access and that they have been instructed on its use .All nursing personnel must always be aware of call lights. Ensure call light is within reach of resident prior to leaving the residents room .Be sure call lights are placed near the resident, never on the floor or bedside stand.This citation relates to Intakes 2605799 and 2613777. 3.1-3(v)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure facial hair trimming and nail care was provided for 2 of 6 residents reviewed for Activities of Daily Living. (Residents Q and W) Findings include: 1. The clinical record for Resident W was reviewed on 9/17/25 at 1:00 p.m. The diagnoses included, but were not limited to, heart failure. An Annual Minimum Data Set (MDS) assessment, dated 9/2/25, indicated Resident W was moderately cognitively impaired. An Activity of Daily Living (ADLs) care plan for Resident W, dated 12/14/24, indicated the staff was to during “BATHING: Check nail length and trim and clean on bath day and as necessary.” An observation was conducted of Resident W on 9/17/25 at 2:16 p.m. The resident was sitting in her wheelchair in the dining room. The resident's nails were observed to be long in length and a black substance underneath them. The resident indicated at that time; she would like them trimmed. An observation was conducted of Resident W in bed on 9/18/25 at 9:32 a.m. Resident W's nails were observed long in length. August and September 2025 bathing sheets were provided, for Resident W, by the Assistant Director of Nursing (ADON) on 9/22/25 at 2:00 p.m. The following days indicated nail care was not documented as provided: 8/5/25, 8/29/25, 9/2/25, 9/4/25, and 9/15/25. An interview was conducted with the ADON on 9/22/25 at 2:58 p.m. She indicated nail care should be provided on bathing days. She would trim Resident W's nails at that time. 2. The clinical record for Resident Q was reviewed on 9/18/25 at 10:00 a.m. His diagnoses included, but were not limited to, Parkinson's disease and history of fractures. The ADL care plan, revised 7/1/25, indicated he had an ADL self-care performance deficit. He required assistance with bathing and personal hygiene. The 8/10/25 Quarterly MDS assessment indicated he was moderately cognitively impaired. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of Resident Q was conducted on 9/18/25 at 10:08 a.m. He had long, unkempt facial hair. An interview was conducted with Resident Q on 9/18/25 at 10:34 a.m. He indicated he'd been asking to be shaved for the past three weeks. An observation of Resident Q was conducted on 9/22/25 at 12:58 p.m. His facial hair was freshly shaven. The September 2025 shower sheets indicated he was last shaved on 9/15/25. An interview was conducted with Resident Q on 9/22/25 at 3:18 p.m. He indicated staff just shaved his facial hair yesterday, but he'd been asking for last two or three weeks. A Quality-of-life resident rights policy was provided by the Executive Director on 9/22/25 at 2:46 p.m. It indicated, “To ensure that all residents are treated with the level of dignity they are entitled to while residing at the facility…Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect and individuality…” The Shaving policy was provided by the ED (Executive Director) on 9/23/25 at 9:52 a.m. It indicated, I. The Facility provides for the removal of facial hair as a component of the resident's hygienic program. II. Male residents may be shaved daily, and female resident may be shaved as needed. This citation relates to Intakes 2605799 and 2613777. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)

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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. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a resident with chronic pain and polyosteoarthritis had a care plan to address her pain; administer as needed pain medication timely; and document vital signs and non-pharmacological interventions for as needed pain medication administrations, as ordered, for 2 of 2 residents reviewed for pain. (Resident N and Resident BB)Findings include:1. The clinical record for Resident N was reviewed on 9/17/25 at 12:30 p.m. Her diagnoses included, but were not limited to, chronic pain, polyosteoarthritis, chronic obstructive pulmonary disease, chronic kidney disease, and heart failure. There was no care plan to address Resident N's chronic pain. An interview was conducted with Resident N on 9/17/25 at 12:18 p.m. She indicated she had arthritis in her legs. It hurt to sit in her wheelchair. She wasn't currently in pain, only if she moved. The physician's orders indicated to administer one 25 milligram (mg) tablet of tramadol every eight hours as needed for chronic pain. They indicated, Pain assessment Before and After PRN [as needed] Meds [medications:] Utilize 0-10 Pain Scale or PAINAD [pain assessment in advanced dementia.] Document Pain Scale Results, v/s [vital signs,] interventions, outcomes, in Progress Notes. Utilize the non-pharmacological Pain Treatment code: P-Position R- Relaxation H-Heat C-Cold M-Music O-Other as needed for Pain. Document Interventions both non-med and Medications in Progress Notes in [name of electronic health record,] effective 12/23/24. The September 2025 MAR (medication administration record) indicated she was administered the tramadol on 9/4/25 and 9/19/25. The September 2025 TAR (treatment administration record) was blank for the 9/4/25 and 9/19/25 PRN tramadol administrations regarding the pain assessment order. The corresponding 9/4/25 and 9/19/25 progress notes in the electronic health record did not include vital signs or non pharmacological interventions. The 9/4/25 corresponding progress note indicated the effect of the medication was unknown. An interview was conducted with the Director of Nursing (DON) on 9/22/25 at 12:00 p.m. She indicated they just created a pain care plan today, but she had an old one from a previous stay. 2. The clinical record for Resident BB was reviewed on 9/17/25 at 2:00 p.m. His diagnoses included, but were not limited to: cancer, right femur fracture, peripheral vascular disease, inguinal hernia, and spinal stenosis. The pain management care plan, revised 8/20/25, indicated two of the goals were for him to not have any interruption in normal activities due to pain and for him to verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Interventions were to anticipate his need for pain relief and respond immediately to any complaint of pain, and to encourage him to try different pain-relieving methods like positioning, relaxation, therapy, bathing, health and cold application, and muscle stimulation. The 8/15/25 admission Minimum Data Set assessment indicated he was cognitively intact. An interview was conducted with Resident BB on 9/17/25 at 2:32 p.m. He indicated he asked for a pain pill at 9:00 p.m. last night, and no one gave it to him. He asked again at 11:00 p.m., and didn't get it until 1:37 a.m. He had pain in his hip, knee, and heel. He hurt all over. He received his sleeping pill at the same time, so he didn't get that until 1:37 a.m. either. He stated, It's ridiculous. This happened daily, especially at night. The physician's orders indicated to administer one tablet of oxycodone-acetaminophen every four hours as needed for chronic pain, effective 9/3/25. They indicated, Pain assessment Before and After PRN Meds [medications:] Utilize 0-10 Pain Scale or PAINAD [pain assessment in advanced dementia.] Document Pain Scale Results, v/s [vital signs,] interventions, outcomes, in Progress Notes. Utilize the non-pharmacological Pain Treatment code: P-Position R- Relaxation H-Heat C-Cold M-Music O-Other as needed for Pain. Document Interventions both non-med and Medications in Progress Notes in [name of electronic health record,] effective 8/9/25. The September 2025 MAR indicated he was administered the oxycodone-acetaminophen as needed on the following dates: twice on 9/3/25, once on 9/5/25, three times on 9/7/25, twice on 9/8/25, twice on 9/9/25, twice on 9/10/25, once on 9/13/25, twice on 9/14/25, three times on 9/15/25, twice on 9/16/25, twice on 9/17/25, three times on 9/18/25, once on 9/19/25, twice on 9/20/25, and three times on 9/21/25. One of the administrations, on 9/17/25, was documented as given at 1:41 a.m., which coincided with Resident BB's interview of when he received the medication. The September 2025 TAR was blank for the above PRN oxycodone-acetaminophen administrations regarding the pain assessment order. The corresponding progress notes in the electronic health record did not include vital signs or non- pharmacological interventions. An interview was conducted with the DON on 9/22/25 at 10:56 a.m. She indicated they obtained vital signs when a resident complained of pain, because their temperature or blood pressure could change. They documented in the MAR/TAR, but not necessarily anywhere else. The DON reviewed