| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155245 | A. Building<br>B. Wing | 11/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Castleton Health Care Center | 7630 E 86th St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on observation, interview, and record review, the facility failed to treat residents with dignity and respect related to speaking to residents in a respectful way, providing services timely, answering call lights timely, and providing privacy for 10 of 14 residents reviewed for dignity ( Residents B, C, D, E, H, J, K, L, M, and T).Findings include: 1. A Resident Council Meeting was held on 11/6/25 at 11:01 a.m. The residents in attendance were Resident B, C, E, H, J, K, L, and M. During the Council meeting the residents indicated the staff would come in and turn call lights off without providing the service needed and then leave the room and not return to perform the care requested. At times residents would wait one to two hours to have their call light answered. The staff spoke disrespectfully to them and were rude when providing care. The staff had earbuds in and appeared to be having conversations with other people while providing care for the residents. The staff talk loudly in the hallways, using residents' names, about care that had been provided to other residents, such as those who had soiled themselves and who the staff did not want to care for on their shifts. These concerns presented themselves more often on the evening shift, night shift, and on the weekends. Resident B and Resident L indicated there was fighting going on between the different shifts about what care had been provided. Resident H indicated she was frequently not gotten up for bingo and felt that she was too much work to take care of because of this. Resident C indicated she wondered if the call light system was broken because of the amount of time it took the staff to answer the call lights. The Resident Council representative indicated they had brought these concerns to the management staff, but the problems had not been resolved. On 11/6/25 at 2:52 p.m., the Activities Director (AD) provided the Resident Council Minutes for meetings held on the 10/20/25, 10/27/25, and 11/3/25. The 10/20/25 meeting notes indicated new business included: call lights, when residents ask for something, they are told staff are too busy, staff with phones out continued to be a problem and ear buds being worn while working was still a problem. Staff were on their phones yelling and using profanity. Some of the staff continued to behave unkind and disrespectfully toward residents. Staff discuss what they are not going to do in front of residents. The meeting notes, dated 10/27/25, indicated new business included: weekend and evening staff needed to improve their customer service skills. Call lights are not being answered timely, and staff are still on their phones and wearing ear buds. The meeting notes, dated 11/3/25, indicated new business included: weekend and evening staff needed to improve their customer service skills. Call lights are not answered timely, and staff are still on their phones and wearing ear buds. 2.During an observation on 11/6/25 at 3:20 p.m., Resident D's call light was visibly on above his door and was sounding at the nurses' station. At 3:33 p.m., Certified Nursing Assistant (CNA) 2 was observed in the unit pantry preparing ice water to pass. Resident D's call light continued to be on, and Resident T's call light was also visible above her door and sounding at the nurses' station. Licensed Practical Nurse (LPN) 5 arrived at the unit. At 3:36 p.m., CNA 2 began to pass ice water on the Sunset Boulevard hallway. Resident D's and Resident T's call lights continued to sound. At 3:39 p.m., LPN 4 came to the unit and was standing at a medication cart, working on a computer. CNA 2 continued to pass ice water going from room to room down the Sunset Boulevard hallway until coming to Resident T's room at 3:44 p.m. CNA 2 then entered Resident T's room, and the call light was turned off. CNA 2 then exited Resident T's room and continued to pass ice water. Resident D's call light continued to be visible and was sounding at the nurses' station. At 3:46 p.m., LPN 5 was standing at a medication cart, she left the medication cart and started going from room to room down the Shoreline Court hallway. At 3:50 p.m., LPN 5 entered Resident D's room, and the call light was turned off and LPN 5 exited Resident D's room. At 3:55 p.m., Resident D was observed with the room of his door open, lying in his bed with his pants down at his knees. He had an indwelling urinary catheter leg bag present on his right leg. Resident D indicated his light had been on because he needed to be cleaned up. At 3:59 p.m., LPN 5 and another nursing staff member were at the Shoreline Court medication cart, counting the narcotic medications. Other staff were observed on the unit talking with each other. At 4:04 p.m., CNA 3 indicated she was assigned to care for Resident D on the evening shift. She had not been informed he needed any care. CNA 3 went to Resident D's room and asked him what he needed. Resident D indicated he had been waiting for 2 hours to be cleaned up. CNA 3 covered Resident D with a sheet. Resident D's side of the room did not have a privacy curtain available to close. CNA 3 indicated Resident D was alert and able to answer questions accurately. Resident D did not have a privacy curtain available to pull around his bed. The clinical record for Resident D was reviewed on 11/6/25 at 3:20 p.m. The residents' diagnosis included, but were not limited to, cerebral palsy and depression. A Quarterly |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, interview and record review, the facility failed to ensure a resident was shaved and that a resident received toileting care timely for 2 of 3 residents reviewed for Activities of Daily Living (ADL) care. (Resident J and Resident D)Findings include:1 The clinical record for Resident J was reviewed on 11/5/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, hemiplegia (paralysis or weakness on one side of the body) and stroke.<br><br>A care plan, with a revision date 8/24/24, indicated the resident required assistance with self-care. Resident J was to be shaved on shower days.<br><br>A care plan for bathing, with a revision date of 8/20/24, indicated the resident preferred to receive bed baths and required total staff assistance with his bathing.<br><br>During an observation, on 11/5/25 at 2:08 p.m., Resident J was observed with long facial hair sitting in his wheelchair in the small dining area on the unit.<br><br>During a resident council meeting on 11/6/25 at 11:00 a.m., Resident J was observed with long facial hair. He indicated he would like to be shaved, but the staff do not offer to shave him.<br><br>The October and November 2025 bathing records for Resident J were provided on 11/6/25 at 2:00 p.m., by the Corporate Minimum Data Set (MDS) Coordinator. The following days the resident had received a bed bath, but did not indicate the resident was shaved: 10/24/25, 10/28/25, 10/31/25, and 11/4/25<br><br>An interview was conducted with the Executive Director on 11/7/25 at 8:35 a.m. She indicated she was unsure why Resident J was not provided shaving on bathing days.<br><br>2. The clinical record for Resident D was reviewed on 11/6/25 at 3:20 p.m. The resident's diagnosis included, but were not limited to, cerebral palsy and depression.<br><br>A Quarterly Minimum Data Set (MDS) Assessment, completed 9/11/25, indicated the resident had moderately impaired cognitive ability. He was able to make himself understood and understand what was said to him. He required supervision or touch assistance from staff for personal hygiene and toileting.<br><br>During an observation, on 11/6/25 at 3:20 p.m., Resident D's call light was observed to be on and was answered by Licensed Practical Nurse (LPN) 5 at 3:50 p.m. At 3:55 p.m., Resident D was observed with the door of his room open, lying in his bed with his pants down at his knees. He had an indwelling urinary catheter leg bag present on his right leg. Resident D indicated his light had been on because he needed to be cleaned up. At 4:04 p.m., Certified Nursing Assistant (CNA) 3 indicated she was assigned to care for Resident D on the evening shift. She had not been informed Resident D needed any care. CNA 3 went to Resident D's room and asked him what he needed. Resident D indicated he had been waiting for 2 hours to be cleaned up. He was still lying uncovered on his bed. CNA 3 covered Resident D with a sheet.<br><br>During an interview, on 11/6/25 at 4:05 p.m., CNA 3 indicated Resident D was alert and able to answer questions and make his needs known. CNA 3 indicated Resident D needed his incontinent brief changed and she would provide the care right away.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview, on 11/6/25 at 4:15 p.m., the Executive Nurse Consultant (ENC) indicated the call lights should have been answered timely and care should have been provided.<br><br>A shaving policy was provided by the Executive Director on 11/7/25 at 1:33 p.m. It indicated, Purpose: To increase cleanliness and improve the resident's self-image. Policy 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. Procedure.x. Document procedure or resident's refusal of the shave in the resident's medical record.<br><br>This citation is related to 2654328.<br><br>3.1-38(a)(3) |