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	03/06/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review, the facility failed to protect the resident's right to be free from misappropriation of property for 3 of 3 residents reviewed. Narcotic pain medication was missing, and extra doses were documented as given. (LPN 2, Resident B, Resident C, Resident D) Findings include:1. During an interview on 3/4/26 at 7:12 a.m., Resident B indicated staff told him that his pain medication was missing a few weeks ago.The clinical record for Resident B was reviewed on 3/4/26 at 9:12 a.m. The diagnoses included, but were not limited to, ankylosing spondylitis (a chronic inflammatory autoimmune arthritis causing pain) and muscle weakness.A quarterly Minimum Data Set (MDS) assessment, dated 1/28/26, indicated Resident B was cognitively intact.A current physician's order started on 5/19/25, indicated oxycodone (narcotic pain medication)/acetaminophen 10 milligrams (mg)/325mg administer one tablet orally every six hours for pain.On 3/5/26 at 10:45 a.m., the Administrator provided a copy of a facility investigation, dated 1/23/26, and indicated this was the investigation regarding Resident B's missing oxycodone/acetaminophen 10/325mg. The investigation included the following:- A signed statement, dated 1/23/26, indicated the Director of Nursing (DON) removed Resident B's oxycodone/acetaminophen 10/325mg from the locked medication cart. The statement was signed by Qualified Medication Aide (QMA) 1.- A signed statement, dated 1/23/26, indicated the DON had removed several medications from the medication carts. The DON did not remove any medication for Resident B. The DON was not aware of what happened to Resident B's oxycodone/acetaminophen 10/325mg. The statement was signed by the DON.- A pharmacy delivery slip, dated 1/8/26 at 5:02 p.m., indicated prescription number ****921, 40 tablets of oxycodone/acetaminophen 10/325mg was delivered for Resident B.- A Controlled Drug Record, dated 1/8/26, indicated prescription number ****921, 40 tablets of oxycodone/acetaminophen 10/325mg, starting balance 40 tablets. No tablets were signed out as administered from the controlled drug record. During an interview on 3/5/26 at 10:45 a.m., the Administrator indicated the facility was unable to substantiate any staff who took Resident B's oxycodone/acetaminophen 10/325mg. The pharmacy reported Resident B should have had 40 tablets available in the locked medication cart.2. On 3/5/26 at 9:34 a.m., the Administrator provided a timeline of events, dated 2/18/26. A review of the timeline of events indicated the following:- On 2/17/26 at 5:58 p.m., Licensed Practical Nurse (LPN) 2 documented on a narcotic count sheet that she administered two tablets of oxycodone/acetaminophen 5/325mg to Resident C on a Controlled Drug Record for prescription number ****8204.- On 2/17/26 at 5:58 p.m., LPN 2 documented on a narcotic count sheet that she administered two tablets of oxycodone/acetaminophen 5/325mg to Resident C on a Controlled Drug Record for prescription number ****9542. - On 2/17/26 at 8:00 p.m., LPN 2 documented that she administered two tablets of hydrocodone/acetaminophen 5/325mg to Resident D on a Controlled Drug Record.On 3/5/26 at 10:45 a.m., the Administrator provided a copy of a hand-written statement, dated 2/17/26. A review of the statement indicated LPN 2 was made aware that Resident C's physician's order for oxycodone/acetaminophen 5/325mg had been changed. Resident B's oxycodone/acetaminophen 5/325mg had been accounted for at the end of LPN 2's shift. The statement was signed by LPN 2. At that time, the Administrator indicated LPN 2 was terminated for improper handling of controlled substances and documentation discrepancies involving multiple (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents. She denied taking any medications. She could not explain her documentation for Resident C or Resident D and the attending physician confirmed LPN 2 was never given a one-time order for one extra tablet of hydrocodone/acetaminophen 5/325mg to administrator to Resident D.The clinical record for Resident C was reviewed on 3/6/26 at 9:12 a.m. The diagnoses included, but was not limited to, paraplegia, diabetes, and anxiety.A quarterly Minimum Data Set (MDS) assessment, dated 2/17/26, indicated Resident C was cognitively impaired.A current physician's order started on 12/16/25, indicated oxycodone/acetaminophen 5/325mg administer two tablets every eight hours as needed for pain.A Narcotic Administration Record, dated 1/28/26 at 7:00 p.m. until 2/17/26 at 5:58 p.m., indicated prescription number ****8204, LPN 2 initialed that she had removed two oxycodone/acetaminophen 5/325mg tablets on 2/17/26 at 5:58 p.m.A Narcotic Administration Record, dated 2/17/26 at 5:58 p.m., indicated prescription number ****9542, LPN 2 initialed that she had removed two oxycodone/acetaminophen 5/325mg tablets on 2/17/26 at 5:58 p.m.The clinical record for Resident D was reviewed on 3/6/26 at 9:31 a.m. The diiagnoses included, but were not limited to, dementia, epilepsy, and cognitive communication deficit.A current physician's order started on 5/30/25, indicated hydrocodone (narcotic pain medication)/acetaminophen 5/325mg administer one tablet orally four times daily for pain.The Controlled Drug Record, dated 2/9/26 at 4:00 p.m. until 2/18/26 at 1:00 p.m., indicated LPN 2 signed that she had removed two hydrocodone/acetaminophen 5/325mg tablets on 2/17/26 at 8:00 p.m.An undated written statement indicated LPN 2 was not given any one-time order to administer one extra table of hydrocodone/acetaminophen 5/325mg on 2/17/26. The statement was signed by the attending physician.On 3/5/26 at 9:34 a.m., the Administrator provided a copy of a letter on company letterhead, dated 2/25/26, and indicated this was a copy of the termination letter that was provided to LPN 2. A review of the letter indicated LPN 2 was terminated effective 2/25/26.On 3/6/26 at 10:00 a.m., the Administrator provided a copy of a facility policy, titled Abuse Prevention and Prohibition Program, dated 8/2020, and indicated this was the current policy used by the facility. A review of the policy indicated each resident has the right to be free from misappropriation.This citation relates to Intake 2708112.410 IAC (Indiana Administrative Code) 16.2-3.1- 3.1-28(a)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report two allegations of misappropriation of the residents' narcotic pain medications with complete and accurate information and within the appropriate time frames for 2 of 3 incidents reviewed for reporting. Findings include:1. On 3/4/26 at 9:02 a.m., the Administrator provided a copy of a facility reportable incident, dated 1/23/26 at 1:15 p.m. A review of the reportable incident indicated the following:- The resident Involved was left blank- The staff involved was left blank- The Brief Description of Incident, dated 1/31/26 (eight days after the initial allegation was reported to the Administrator), indicated, on 1/23/26 at 1:25 p.m., a Qualified Medication Aide (QMA) reported that she called the pharmacy to request a refill of a resident's oxycodone (narcotic pain medication) 10 milligrams (mg) /325mg. The pharmacy informed the QMA that it was too early to refill. The resident should have had 40 tablets at the facility. The QMA reported that the Director of Nursing (DON) removed the medication from the medication cart earlier in the shift. The DON had been placed on administrative restrictive leave.- Type of Injury, dated 1/31/26, indicated not applicable.- Immediate Action Taken, dated 1/31/26, indicated the DON was suspended pending the investigation.- Follow-up, dated 2/5/26 (13 days after the incident was initially reported to the Administrator), indicated the facility was unable to substantiate the allegation of misappropriation of a resident's narcotic pain medication.2. On 3/5/26 at 9:34 a.m., the Administrator provided a copy of a facility reportable incident, dated 2/17/26 at 10:45 p.m. A review of the reportable incident indicated the following:- The resident Involved was left blank- The staff involved was left blank- Brief Description, dated 2/18/26, indicated during routine controlled drug reconciliation at the beginning of the shift, a discrepancy was identified. The discrepancy was immediately reported to the Assistant Director of Nursing (ADON) and the Administrator.- Follow up, dated 3/5/26 (16 days after the initial report was made to the state health department), indicated the investigation had been completed and the individual had been released from their duties with the facility. A complete audit was conducted on all of the medication cart. Education was provided to all clinical staff. Audits were in place to monitor continued compliance.During an interview on 3/5/26 at 10:45 a.m., the Administrator indicated the staff and residents' names involved in each of the facility reportable incidents should have been included in the initial report. The misappropriation incidents should have been reported to the state health department within 24 hours, and the follow-ups should have been reported within five days of the incident.On 3/6/26 at 10:00 a.m., the Administrator provided a copy of a facility policy, titled Abuse Prevention and Prohibition Program, dated 8/2020, and indicated this was the current policy used by the facility. A review of the policy indicated the facility promptly and thoroughly reports and investigates allegations of allegations of abuse.This citation relates to Intake 2708112.410 IAC (Indiana Administrative Code) 16.2-3.1-28(c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure a resident had a comprehensive person-centered discharge care plan in place for 1 of 3 residents reviewed for discharge. (Resident F) Findings include:The clinical record for Resident F was reviewed on 3/4/26 at 10:15 a.m. The diagnoses included, but were not limited to, traumatic brain injury, acute respiratory failure, cannabis dependence, and alcohol dependence.A progress note, dated 2/10/26 at 4:30 p.m., indicated Resident F discharged with medications and belongings.The clinical record for Resident F lacked a person-centered discharge care plan.During an interview on 3/6/26 at 12:10 p.m., Licensed Practical Nurse (LPN) 1 indicated Resident F should have had a person-centered care plan for discharge in place and a copy of the discharge care plan should have been provided when he discharged .On 3/4/26 at 9:30 a.m., the Administrator provided a copy of a facility policy, titled Transfer and Discharge, dated 6/2020, and indicated this was the current policy used by the facility. A review of the policy indicated the resident will have a comprehensive person-centered discharge care plan.This citation relates to Intake 2743057.410 IAC (Indiana Administrative Code) 16.2-3.1- 3.1-35(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure controlled medications were reconciled accurately during delivery for 3 of 3 residents reviewed for pharmaceutical services. (Resident B, Resident C, Resident D) Findings include:1. On 3/5/26 at 10:45 a.m., the Administrator provided a copy of a pharmacy delivery slip and a Controlled Drug Record for Resident B. A review of the documents indicated the following:- A pharmacy delivery slip, dated 1/8/26 at 5:02 p.m., indicated prescription number ****921, 40 tablets of oxycodone/acetaminophen 10/325 mg (millgrams) was delivered for Resident B. The space next to Received By: was left blank, the space next to Delivery Date/Time: was left blank, and the space next to Print Name: was left blank.- A Controlled Drug Record, dated 1/8/26, indicated prescription number ****921, 40 tablets of oxycodone/acetaminophen 10/325 mg were delivered for Resident B. The space next to Starting balance was left blank, the space next to Checked in By was left blank, and the space next to Date was left blank. No tablets were signed out as administered from the controlled drug record. 2. The clinical record for Resident C was reviewed on 3/6/26 at 9:12 a.m. The diagnoses included, but was not limited to, paraplegia, diabetes, and anxiety.A Narcotic Administration Record, dated 1/28/26 at 7:00 p.m. until 2/17/26 at 5:58 p.m., indicated Resident C's prescription number ****8204, oxycodone/acetaminophen 5/325 mg, the space next to Checked in By was left blank and the space next to Date was left blank.A Narcotic Administration Record, dated 2/17/26 at 5:58 p.m., indicated Resident C's prescription number ****9542, oxycodone/acetaminophen 5/325mg, the space nest to Starting Balance was left blank.3. The clinical record for Resident D was reviewed on 3/6/26 at 9:31 a.m. The diagnoses included, but were not limited to, dementia, epilepsy, and cognitive communication deficit.A Controlled Drug Record, dated 2/9/26 at 4:00 p.m. until 2/18/26 at 1:00 p.m., indicated Resident D's prescription number ****9277, hydrocodone/acetaminophen 5/325mg, the space next to Checked in By' was left blank and the space next to Date was left blank.During an interview on 3/6/26 at 11:45 a.m., LPN 3 indicated the pharmacy delivery slips and the Controlled Drug Record for Resident B, Resident C, and Resident D should have been filled in completely by the nurse that received those medications from the pharmacy.On 3/5/26 at 10:45 a.m., the Administrator provided a copy of an undated facility policy, titled Receiving Medications from Pharmacy, and indicated this was the current policy used by the facility. A review of the policy indicated when medications are delivered check the delivery manifest at the time of delivery against what is being delivered. If the manifest is correct, manually sign the appropriate space with name, date and time.This citation relates to Intake 2708112.410 IAC (Indiana Administrative Code) 16.2-3.1-25(e)(2)