| 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 | 04/27/2026 |

| 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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on interview and record review, the facility failed to ensure residents reviewed for receipt of medications routinely received their physician-ordered medications and the medication receipt was documented in each resident's clinical record to reflect the receipt of the medications for 4 of 4 residents reviewed for pharmacy services. (Residents B, C, D and E) Findings include:1.The clinical record of Resident C was reviewed on 4-24-26 at 11:46 a.m. His diagnoses included, but were not limited to, ankylosing spondylitis (a chronic inflammatory autoimmune arthritis resulting in spinal stiffness and pain) of unspecified sites in the spine. His medication orders included, but were not limited to, Humira (a biologic medication used in the treatment of autoimmune disorders, such as ankylosing spondylitis) 40 milligrams (mg) to be injected every 14 days subcutaneously (under the skin) for ankylosing spondylitis of unspecified sites in the spine. His medication administration record (MAR) for March, 2026, indicated he received the 3-10-26, dose, but the 3-24-26, dose was blank, indicating it had not been administered as ordered. A review of the progress notes and the MAR for the time period failed to provide any documentation of why the medication was not administered as ordered.In an interview with a friend of Resident C's on 4-24-26 at 9:58 a.m., she indicated Resident C had not received at least two (2) doses of his Humira, but was unable to specify what those dates were. She had notified the Director of Nursing (DON) at that time and he received one of the two doses, but it was late by a few days. In an interview with the DON, Corporate Nurse and Executive Director (ED) on 4-27-26 at 3:05 p.m., the Corporate Nurse indicated when the issue of the undocumented dose of Humira was brought to the facility's attention on 4-24-26, the facility began an investigation. The DON indicated the facility learned the medication for the 3-24-26, was delivered to the facility on 3-13-26, thus meaning it was available to be administered on 3-24-26. She added the nurse who should have administered the injection was no longer employed by the facility which did not allow her to follow up with that nurse to address the discrepancy. 2.The clinical record of Resident B was reviewed on 4-24-26 at 2:33 p.m. His diagnoses included, but were not limited to, necrotizing fasciitis (a rare, life-threatening bacterial infection that destroys skin, fat, and the tissue covering muscles) and anxiety.A review of his medication administration record (MAR) for February, 2026, indicated one physician-ordered medication was not documented as administered as identified by the administration block, was blank, which signifies the medications were not administered. Corresponding documentation in the MAR or the progress notes failed to identify the reason the medications were not administered. Buspar 5 milligrams (mg) three times daily by mouth was not documented to have been administered on 2-2-26 at 1:00 p.m. 3.The clinical record of Resident D was reviewed on 4-27-26 at 12:10 p.m. His diagnoses included, but were not limited to, type 2 diabetes and chronic pain.A review of his medication administration record (MAR) for April, 2026, indicated multiple physician-ordered medications were not documented as administered as identified by the administration block, was blank, which signifies the medications were not administered. Corresponding documentation in the MAR or the progress notes failed to identify the reason the medications were not administered. The undocumented medications were as follows:-Gabapentin 300 milligrams (mg) 2 tablets for a total of 600 mg three times daily at 6:00 a.m., 2:00 p.m. and 10:00 p.m., (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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | for neuropathy (nerve damage) were not documented as administered on 4-1-26 and 4-4-26 at 10:00 p.m.-HumaLOG KwikPen (short-acting insulin) 100 UNIT/ML strength inject subcutaneously (under the skin) three times daily on a sliding scale basis (based on the blood glucose level). The MAR failed to identify the blood glucose was obtained and the corresponding insulin was administered on 4-16-26 and 4-18-26 at 8:00 a.m. and 12:00 p.m., and 4-19-26 at 8:00 a.m. 4.The clinical record of Resident E was reviewed on 4-23-26 at 2:42 p.m. Her diagnoses included, but were not limited to unspecified psychoses, anxiety, depression, type 2 diabetes, polyosteoarthritis (degenerative disease where osteoarthritis affects five or more joints) and polyneuropathy (damage to multiple nerves throughout the body).A review of her medication administration record (MAR) for April, 2026, indicated multiple physician-ordered medications were not documented as administered as identified by the administration block, was blank, which signifies the medications were not administered. Corresponding documentation in the MAR or the progress notes failed to identify the reason the medications were not administered. The undocumented medications were as follows:-Buspar (an anti-anxiety medication) 15 milligrams (mg) three times a day for anxiety was not administered on 4-1-26 at 5:00 p.m.-Eliquis (an anticoagulant medication) 2.5 mg twice daily for anticoagulation therapy was not administered on 4-1-26 at 6:00 p.m.-Lyrica (an anticonvulsant and pain medication) 75 mg twice daily for pain was not administered on 4-1-26 at 6:00 p.m.-Ropinirole (a dopamine antagonist used in the treatment of restless leg syndrome) 1 mg twice daily for restless leg syndrome was not administered on 4-1-26 at 6:00 p.m.-Quetiapine Fumarate (an anti-psychotic medication) 50 mg at bedtime for depression was not administered on 4-1-26 at 9:00 p.m.-Famotidine (a histamine receptor antagonist used to decrease stomach acid production) 10 mg at bedtime for stomach discomfort was not administered on 4-1-26 at 9:00 p.m. On 4-27-26 at 3:16 p.m., the Director of Nursing provided a copy of an undated policy entitled, Medication Error Reporting. This policy indicated its purpose as To develop policies and procedures for proper distribution of resident's medications. It indicated, The facility Administrator shall ensure that all nursing employees who distribute medication [sic] are oriented and comply with the facility's medication distribution policy. If a medication error should occur, the nursing employee making the medication error, or if different, the Nurse finding the medication error shall complete a medication report. A Medication Error Report shall be completed whenever it is indicated that there is a medication error, treatment error or documentation error. The form shall be initiated by the Licensed Nurse who discovered the error. The Director of Nursing or Assistant Director of Nursing shall be notified .shall direct the investigation, notification of the physician and family, and appropriate follow-up. The completed Medication Error Report shall be signed by the Director of Nursing and forwarded to the Administrator .The Administrator and Director of Nursing shall analyze the occurrence and determine the appropriate counseling . On 4-27-26 at 3:16 p.m., the Director of Nursing provided an undated copy of an educational training entitled, Medication Not Available in the Medication Cart. This training information indicated, When a prescribed medication is not available in the medication cart, prompt action is essential to ensure resident safety, maintain continuity of care and comply with regulatory requirements. Immediate Steps: Verify the order .Check the Emergency Drug Kit .Contact the Pharmacy .Notify the Provider .Notify the Resident and Family/Responsible Party .Document thoroughly in the medical record, including: medication name, dose and scheduled administration time, steps taken to locate the medication, pharmacy contact, including date, time and representative spoke to, provider notification and any orders received, family/responsible notification, resident assessment and any observed effects, follow-up actions taken .follow facility policies and procedures at all times, report recurring medication availability issues to nursing leadership. On 4-26-26 at 12:26 p.m., the Executive Director and Director of Nursing were electronically requested to provide copies of the facility's policies and procedures for medication and treatment administration documentation. As of exit from the survey on 4-27-26, this information had not been provided. This citation relates to Intakes 2975067 and 2981085. 410 IAC (Indiana Administrative Code 3.1-25(b)(3)410 IAC (Indiana Administrative Code 3.1-25(b)(9) |