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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident at risk for developing pressure ulcers and identified with redness to the right heel upon admission to the facility, had thoroughly completed skin assessments and identification of risk factors to where the resident (Resident BB) complained of pain and was identified with a stage (3) three pressure ulcer (full-thickness skin loss, penetrated through the top two layers of skin and into the fatty tissue beneath) that required ongoing treatment for 1 of 3 residents reviewed for quality of care. (Resident BB)Findings include: The clinical record for Resident BB was reviewed on 9/19/25 at 2:10 p.m. The diagnoses included, but were not limited to, fracture of right femur, hypertension, peripheral vascular disease, congestive heart failure, atrial fibrillation, diabetes mellitus, and muscle weakness. Resident BB was admitted to the facility on [DATE]. An admission assessment, dated 8/9/25, indicated Resident BB had skin issues. That included, but was not limited to, redness to right heel. There was no further description, measurements, or further assessment of the redness to Resident BB's right heel. A Braden Scale (clinical tool for predicting resident's risk of developing pressure ulcers), dated 8/9/25, indicated Resident BB was mild risk for pressure ulcer development. An admission Minimum Data Set (MDS) assessment, dated 8/15/25, indicated Resident BB was cognitively intact, had no pressure ulcers, was at risk for developing pressure ulcers, had no venous and/or arterial ulcers, had a surgical wound, had impairment to one side of lower extremities, required substantial/maximal assistance with rolling left and right, dependent with lower body dressing and putting on/taking off footwear, dependent with sit to lying and lying to sitting, sit to stand and chair to bed, and/or bed to chair transfer. A weekly skin assessment, dated 8/16/25, indicated no skin concerns. A physician's note, dated 8/19/25, indicated Resident BB had fatigue, weakness, pain to back, decreased range of motion, decreased muscle tone, and fragile skin. An activities of daily living (ADL) care plan, dated 8/20/25, indicated Resident BB had an ADL self care deficit related to impaired balance, limited mobility, and recent mechanical fall resulting in right femur fracture. The interventions included, but were not limited to, extensive staff participation to reposition and turn in bed. A care plan for peripheral vascular disease, dated 8/20/25, indicated the interventions included, but were not limited to, encourage resident to change position frequently, monitor the extremities of signs and symptoms of injury, infection, or ulcers, and inspect feet daily. A care plan for right hip fracture, dated 8/20/25, indicated Resident BB had a right hip fracture with surgical intervention completed prior to admitting to the facility. The interventions included, but were not limited to, monitor limb for swelling and skin changes. The medication administration/treatment administration record (MAR/TAR), for August 2025, did not indicate any preventative measures put into place regarding the redness to Resident BB's right heel and/or being at risk for pressure ulcer development. A Nurse Practitioner (NP) note, dated 8/22/25, indicated skin: ulcers to right foot. There were no further assessments conducted pertaining to the ulcers mentioned to Resident BB's right foot. A weekly skin assessment, dated 8/23/25, indicated no skin concerns. A progress note, dated 8/25/25 at 1:35 p.m., indicated Resident BB was complaining of pain to his right heel. An open area was noted on the heel of his right foot. Resident was assessed by the NP, and a treatment was ordered for the area to the right heel. A (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Change in Condition Evaluation document, dated 8/25/25, indicated Resident BB was noted with an abrasion to the right heel and was complaining of pain to the right heel. There was no further assessment conducted of the area to Resident BB's right heel. A physician's order, dated 8/26/25, indicated Left heel - cleanse area to left heel with normal saline/wound cleanser, pat dry, apply calcium alginate, cover with optifoam dressing q day [every day] and PRN [as needed] for soilage. in the morning. This order was inconsistent with the Change in Condition Evaluation document and progress note, dated 8/25/25, referencing an area located to Resident BB's right heel. The TAR for August of 2025 indicated the initial treatment was signed off, as completed, on 8/27/25, for the treatment to Resident BB's left heel. On 8/28/25, a would culture was ordered for Resident BB's right heel wound. A physician's order, dated 8/28/25, indicated to cleanse the left heel, pay dry, apply silver alginate, cover with optifoam dressing, and change the dressing daily or as needed. The order was discontinued on 9/11/25. This order was inconsistent with the Change in Condition Evaluation, on 8/25/25, and the progress note, on 8/25/25, indicating an open area to Resident BB's right heel. There were no skin assessments, progress notes, or other information that indicated Resident BB had any skin concerns to the left heel. A physician's order, dated 8/28/25, indicated to administer doxycycline (antibiotic) 100 milligrams (mg) every 12 hours for wound care for ten days. A wound provider note, dated 9/4/25, indicated a stage 3 pressure ulcer was noted to Resident BB's right heel. The wound measured 3.5 centimeters (cm) in length x 4.5 cm in width x 0.1 cm in depth. There was a large amount of necrotic tissue to the wound. Resident BB was diagnosed with cellulitis of the right heel and to continue to take doxycycline for ten days. The wound culture result was pending and the resident's potential to heal was poor. A wound provider note, dated 9/11/25, indicated the right heel pressure ulcer was improving. The wound culture results were positive, and Resident BB was started on ciprofloxacin 500 mg twice daily for ten days based on the wound culture results. A wound culture was collected to Resident BB's right heel, on 9/3/25, and reported on 9/12/25. There was heavy growth of Klebsiella Pneumoniae, light growth of Staphylococcus Aureus, moderate growth of Pseudomonas Aeruginosa, and an organism known to possess inducible Beta-Lactamase. A physician's order, dated 9/11/25 and discontinued on 9/13/25, indicated treatment of the left heel with medihoney and silver alginate, cover with optifoam dressing, and change daily. A physician's order, dated 9/13/25, indicated a daily treatment to Resident BB's right heel that was consistent with the wound provider's recommendations. An interview and observation were conducted with Resident BB on 9/17/25 at 2:35 p.m. He indicated he had gone a whole weekend without the bandage being changed to his heel. The bandage was supposed to be changed daily. When he was admitted to the facility, on 8/9/25, his heel/feet were pressed into the footboard. Resident BB was telling the staff for five days in a row that his heel was hurting before they found the wound and then proceeded to remove the footboard from his bed. Resident BB was observed to have a walking/therapy boot to the right foot and no boot to the left foot. Resident BB indicated the staff don't put a boot on his left foot while he's out of bed. An interview and observation were conducted with Resident BB on 9/22/25 at 10:50 a.m. He indicated he had issues with skin impairment to his left heel while he was at the hospital, but it had since healed. He received surgery for his hip fracture and then was admitted to the nursing facility for therapy services. He indicated on Saturday night, 9/20/25, the air mattress he had would not stay inflated. He had to lay in bed and wait for the facility to find a replacement bed and that didn't happen until 9/21/25. The staff put pillows underneath both of his legs and said he would have to wait until they could find another bed. Resident BB pointed to the other bed that was located upon entry into the room. He stated that it was the same type of bed he had when he first admitted , and he was in a room by himself. Resident BB stated, why couldn't I use that bed? Resident BB indicated he was over six feet tall and the bed he had when he first admitted to the facility didn't allow for much room. When he initially complained of pain to his right heel, the staff would give him pain medication but not look at his foot. It was until he kept on complaining of pain, and that's when they identified the open area to his right heel. Resident BB stated he never had any skin concerns to (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	his left heel since he's been at the facility. An interview was conducted with Corporate Nurse 25 on 9/22/25 at 2:05 p.m. She indicated she came to the facility, on 8/26/25, after the area was identified to Resident BB's right heel. The area was open but when she came in to observe the area, on 8/26/25, Resident B was resting his right foot/heel on top of the footboard before the area was assessed. Resident BB was tall and was least measured to be six (6) foot and three (3) inches tall. Resident BB admitted to the facility in a standard bed but when he obtained the open area, the facility placed him in a long bed. The length of a standard hospital bed was 80 inches (6 feet and 8 inches) in length. A policy entitled Pressure Injury Prevention, revised 6/2020, was provided by the Executive Director on 9/22/25 at 1:57 p.m. The policy indicated to complete a Braden Scale Assessment upon admission and quarterly to identify residents at risk for skin breakdown. The nurse would conduct a skin assessment upon admission, readmission, weekly, and as needed. Results of the weekly skin assessment will be documented in the EHR. If the resident was identified as having a wound upon admission, findings will be documented on the admission assessment, and a Wound Monitoring Record will be implemented. A Wound Monitoring Record will be implemented for each identified wound. The nurse will develop a care plan specific to the resident's risk factors such as moisture control, pressure reduction, positioning, mobility, and nutrition in consultation with the attending physician, interdisciplinary team (IDT), registered dietician, and director of rehabilitation services. Nursing staff will monitor interventions for effectiveness and resident tolerance. The care plan will be revised as indicated. The licensed nurse will document effectiveness of pressure injury prevention techniques in the resident's medical record on a weekly basis. 3.1-40(a)(1)3.1-40(a)(2)3.1-40(a)(3)

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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. 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. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	“…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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview and record review, the facility failed to obtain blood sugar readings and administer insulin as ordered by the physician, monitor the effectiveness of an as needed anti-anxiety medication, ensure a narcotic pain medication was administered as ordered, to timely address a dosage for an antidepressant medication that was not available from the pharmacy, and administer a resident's eye medication, as ordered, for 2 of 5 residents reviewed for unnecessary medications, 1 of 2 residents reviewed for discharge, and 1 of 2 residents reviewed for vision services. (Resident 2, Resident S, Resident V, and Resident 64). Findings include: 1 a. The clinical record for Resident 2 was reviewed on 9/18/25 at 10:15 a.m. The resident's diagnoses included, but were not limited to, diabetes, anxiety disorder, chronic kidney disease, and acute and chronic respiratory failure. A care plan, last revised on 5/28/24, indicated Resident 2 had diabetes which placed her at risk for hyperglycemic (high blood sugar) or hypoglycemic (low blood sugar) reactions. The goal was for her to have no complications related to diabetes. The interventions included to perform blood sugar checks as ordered, administer medications as ordered, and monitor labs as ordered. A care plan, last revised on 11/2/24, indicated Resident 2 had a diagnosis of anxiety. The goal was for her to have an improved mood state. The interventions included to administer medications as ordered and to monitor and document side effects and effectiveness. A physician's order, dated 12/19/24, indicated Resident 2 was to receive Lantus (long-acting insulin) 10 units injected subcutaneously two times a day at 8:00 a.m. and 8:00 p.m. The order indicated to hold the insulin for a blood sugar less than 150. A physician's order, dated 12/19/24, indicated she was to receive Humalog (short-acting insulin) 15 units injected subcutaneously three times a day at 9:00 a.m., 1:00 p.m., and 5:00 p.m. The order indicated to hold the insulin for a blood sugar less than 150. A physician's order, dated 2/28/25, indicated Resident 2 was to receive Accu checks (blood sugar checks) twice daily at 8:00 a.m. and 8:00 p.m. The August and September 2025 Medication Administration Records (MARs) indicated Resident 2 received her 10 unit dose of Lantus when her blood sugar reading was below 150 on the following days: 8/7/25 at 8:00 a.m.- blood sugar recorded as 149, 8/9/25 at 8:00 p.m.- blood sugar recorded as 126, 8/21/25 at 8:00 a.m.- blood sugar recorded as 135, 8/21/25 at 8:00 p.m.- blood sugar recorded as 135, 8/22/25 at 8:00 a.m. and 8:00 p.m.- blood sugar recorded at 135 for each administration, 8/23/25 at 8:00 a.m.- blood sugar recorded as 135, 8/31/25 at 8:00 a.m.- blood sugar recorded as 70, 9/18/25 at 8:00 a.m. and 8:00 p.m.- blood sugar recorded as 114 for each administration, and 9/19/25 at 8:00 p.m.- blood sugar recorded as 145. The August and September MARs indicated Resident 2 received her 15 unit dose of Humalog ,with no documented blood sugar readings recorded, for the 1:00 p.m. and 5:00 p.m. administrations, with the exceptions of the following days and times: 8/4/25 at 1:00 p.m.- documented as not given, 8/8/25 at 1:00 p.m.- documented as not given, 8/13/25 at 1:00 p.m.- documented as not given, 8/19/25 at 1:00 p.m.- documented as not given, 8/30/25 at 5:00 p.m.- documented as not given, 8/31/25 at 1:00 p.m.- documented as not given, 9/1/25 at 5:00 p.m.- documented as not given, 9/4/25 at 1:00 p.m.- (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented as not given, 9/9/25 at 1:00 p.m.- documented as not given, and 9/18/25 at 1:00 p.m.- documented as not given. During an interview on 9/22/25 at 11:47 a.m., the Clinical Nurse Consultant (CNC) indicated the insulin should have been held as ordered by the physician. She was unsure why the blood sugars results were not documented on the MARs for the doses of Humalog given at 1:00 p.m. and 5:00 p.m. 1b. A physician's order, dated 9/10/25, indicated Resident 2 was to receive hydroxyzine (an antihistamine used to treat anxiety) 25 milligram (mg) one tablet by mouth every 8 hours as needed for anxiety. During an observation of the medication cart on 9/19/25 at 10:42 a.m., Licensed Practical Nurse (LPN) 11 indicated Resident 2's hydroxyzine had come in from the pharmacy. He removed the medication card containing Resident 2's hydroxyzine and indicated there were six pills missing from the card. The September 2025 MAR did not contain information that the hydroxyzine had been administered since it was ordered. During an interview on 9/22/25 at 11:25 a.m., the Assistant Director of Nursing (ADON) indicated the doses of hydroxyzine 25 mg should have been documented on the MAR when given and documented the effectiveness of the dose given. 2. The clinical record for Resident S was reviewed on 9/18/25 at 10:30 a.m. The resident's diagnoses included, but were not limited to, dysphasia (inability to swallow) and pain in left shoulder. A Quarterly Minimum Data Set (MDS) assessment, completed 6/19/25, indicated she was cognitively intact and received scheduled and as needed pain medications. She received narcotic medications. A physician's order, dated 7/31/25, indicated she was to receive oxycodone-acetaminophen (narcotic pain medication) 5-325 mg one tablet via gastric tube every six hours as needed for pain. A progress note, dated 8/20/25, indicated Resident S had experienced a medication error. Her son and the physician were notified, and a Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) had been ordered for the next day. Resident S was alert and oriented to situation, no acute distress was noted on the assessment. On 9/23/25 at 9:30 a.m., the CNC provided an incident report, dated 8/20/25 at 2:23 p.m., that indicated Resident S had received Norco (narcotic pain medication) 5-325 mg instead of her ordered oxycodone 5-325 mg. Resident S was stable and had no adverse side effects noted. Her vital signs were stable. There were no injuries noted at the time of the incident. The nurse who administered the wrong medication was educated on the five rights of administering medications. During an interview on 9/23/25 at 9:30 a.m., the CNC indicated Resident S should have received her pain medication as ordered by the physician. 3. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated 7/17/25, indicated Resident V was to receive 150 milligrams of bupropion (antidepressant) in the evenings. The medication was changed on 8/6/25. A physician's order, dated 8/6/25, indicated Resident V was to receive 1.5 tablets for a total dosage of 225 milligrams of bupropion daily. A physician's order, dated 8/25/25, indicated Resident V was to receive 300 milligrams of bupropion daily. The August 2025 Medication Administration Record (MAR) indicated the following days Resident V did not receive 1.5 tablets that equaled 225 milligrams of bupropion: 8/7/25, 8/8/25, 8/9/25, 8/11/25, 8/14/25, 8/16/25, 8/17/25, 8/18/25, 8/20/25, 8/21/25, 8/22/25 and 8/25/25. An interview was conducted with the Executive Director (ED), the Nurse Consultant (NC), and the Director of Nursing (DON) on 9/23/25 at 9:21 a.m. They indicated Resident V was taking 150 milligrams of bupropion as of 7/17/25. The medical provider had increased the resident's dosage to 1.5 tablets totaling 225 milligrams of bupropion daily on 8/6/25. The pharmacy had not notified the facility until 8/11/25; the medication was unable to come in as half tablets. They could not supply the 1.5 tablets. The provider was notified on 8/11/25. The order was changed on 8/26/25 to 300 milligrams of bupropion by the medical provider. An interview was conducted with Nurse Practitioner 8 on 9/23/25 at 9:56 a.m. He indicated he was notified the pharmacy was unable to provide the 1.5 tablets of bupropion a few days prior to the 20th of August. He had seen the resident, and she had reported feeling down. Since the pharmacy was unable to provide 225 milligrams of bupropion due to the inability to supply half tablets, he increased the dosage to 300 milligrams as of 8/25/25. He would have liked to have been notified sooner that the 225 milligrams of bupropion was not available. 4. The clinical record for Resident 64 was reviewed on 9/18/25 at 11:00 a.m. Her diagnoses included, but were not limited to, infected ocular socket lesion and injury of conjunctiva and corneal abrasion. The impaired visual function care plan, revised 10/19/24, indicated she had a detached retina in her right eye and was only able to see out of her left eye. The goal was for her to have no indications of acute eye problems. An interview was conducted with Family Member 4 on 9/18/25 at 11:07 a.m. He indicated he visited Resident 64 on a daily basis. He was present in the facility all day on 9/13/25 and 9/14/25, from 9:00 a.m. to 5:00 p.m. both days. He was unsure whether Resident 64 received her ordered eye drops either day, because he never saw nursing staff administer them. The physician's orders indicated to administer one drop of Refresh Celluvisc Ophthalmic Gel 1 % in both eyes four times a day for dryness from 1/13/25 to 4/21/25. This order was on hold from 3/24/25 to 3/27/25. The same order began again on 5/1/25 and was ongoing for eye health. There were hold dates from 5/9/25 to 5/10/25 and 7/29/25 to 7/31/25. The January 2025 through September 2025 MARs (medication administration records) indicated the eye drops were administered four times daily, as ordered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castleton Health Care Center	7630 E 86th St Indianapolis, IN 46256

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the medication cart contents was conducted with QMA (Qualified Medication Aide) 5 and the DON (Director of Nursing) on 9/19/25 at 12:10 p.m. There were two boxes of Refresh Celluvisc Ophthalmic Gel 1% in the cart. Each box originally contained a total of 30 individually packaged administrations. One box, with an open date of 8/20/25, had 23 administrations left. The other box, dated 3/3/25, had 15 administrations left. The DON indicated they needed to confirm the number of boxes sent from the pharmacy and provided the pharmacy's telephone number. A telephone interview was conducted with the Pharmacist on 9/19/25 at 1:29 p.m. She indicated, since 1/15/25, they delivered three boxes of Refresh Gel, each with 30 administrations per box, for a total of 90 administrations. They were delivered on 1/15/25, 3/4/25, and 8/20/25. One box of Refresh would run out in seven and a half days, if administered four times per day, as ordered, which was 3 weeks worth basically. She stated, There is definitely a long lapse in refilling the Refresh. The 9/13/25 nurse's note indicated she continued on antibiotic therapy related to an eye infection. 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medication storage rooms did not contain expired medication and supplies and failed to ensure medication was stored appropriately and not left unsupervised during the observation of 1 of 2 medication storage rooms and observation of medication administration of 1 of 3 residents. (Resident 80)Findings include: 1. On [DATE] at 10:40 a.m., an observation was conducted of the medication storage room that was located on the rehabilitation hallway of the facility with Licensed Practical Nurse (LPN) 9. In the cabinet there were two boxes of vacutainers (blood collection devices) that expired on [DATE]. The medication storage fridge contained two bottles of liquid medication that were labeled with a sticker that indicated one bottle had expired on [DATE] and the other bottle had expired on [DATE]. Within the fridge, there was a box that contained a vial of tuberculin solution for tuberculosis (TB) skin testing that was opened but had no open date written on the vial nor the box. LPN 9 confirmed the tuberculin solution did not have an open date. 2. An observation of medication administration was conducted with Registered Nurse (RN) 10 on [DATE] at 9:00 a.m. RN 10 had prepared another resident's medication. RN 10 took the medication cup of prepared medications, left the cart, and went down the hallway to administer the medications. While RN 10 was administering the medications, his medication cart remained unlocked and in close proximity to residents in the dining room. There were four residents in the dining room and were able to propel themselves in their wheelchairs while RN 10 left the cart unlocked while administering medications. 3. On [DATE] at 9:07 a.m., RN 10 proceeded to prepare medications for Resident 80. RN 10 retrieved a medication bubble pack for Lomotil (a controlled substance for treatment of diarrhea) and met with resistance while attempting to push the pill medication out of the bubble pack. RN 10 turned the medication card over and there was a white pill but there was a piece of tape covering the pill and making RN 10 not able to press and release the pill from the bubble pack. RN 10 indicated there was an error noted on the narcotic log and the previous nurse might have removed the Lomotil medication by mistake. So, they taped it back into the bubble pack, possibly. RN 10 obtained another pill of Lomotil medication from the bubble pack. At 9:13 a.m., RN 10 accidentally popped a blood pressure medication twice into the medication cup containing Resident 80's medication. RN 10 took a spoon to retrieve the extra blood pressure medication, placed it in another medication cup, and then proceeded to leave the cart to administer medications to Resident 80 but left the medication cup containing the blood pressure medication on top of the medication cart unattended. Nurse Consultant 1 approached the medication cart and indicated the medication should not be left unattended on the medication cart. RN 10 returned to the medication cart, at 9:18 a.m., and Nurse Consultant 1 observed the Lomotil medication and how it was taped to the bubble pack/medication card. Nurse Consultant 1 indicated there was no way to know if the medication taped was the same medication as Lomotil. So, the facility staff was going to destroy the white pill taped on the bubble pack/medication card for Resident 80. On [DATE] at 9:20 a.m., the Director of Nursing (DON) was present and destroyed the medication with RN 10. The DON indicated it was not proper practice regarding taping the medication back into the bubble pack/medication card. A policy entitled Labeling of Medication Containers, revised [DATE], was provided by Nurse Consultant 1 on [DATE] at 12:48 p.m. The policy indicated labels for stock medications to include the expiration date and all medications maintained in the facility were properly labeled in accordance with current state and federal guidelines and regulations. A policy entitled Medication - Administration, undated, was provided by Nurse Consultant 1 on [DATE] at 12:48 p.m. The policy indicated medication administration to be conducted using accepted professional standards and principles and to not leave medications at the bedside. 3.1-25(j)3.1-25(k)(6)3.1-25(o)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure an infection control program that consisted of surveillance and tracking of infections for 6 out of 12 months reviewed, failed to ensure infection control was maintained by a resident's central catheter/PICC (a tube inserted into a vein near the heart) missing the needless connector for 1 of 1 random observation of a resident's central catheter, and failed to ensure linen was properly stored on a hallway linen cart with the potential to affect 18 of 71 residents residing at the facility. (Resident W)Findings include: 1. The infection control binder was reviewed on 9/18/25 at 11:21 a.m. The Infection Preventionist was listed as the Assistant Director of Nursing (ADON). The monthly tracking logs consisted of the following months: April of 2025, May of 2025, June of 2025, July of 2025, and August of 2025. There were no logs to indicate surveillance and monitoring of trends for infections was conducted prior to April of 2025. An interview conducted with the ADON, on 9/19/25 at 11:24 a.m., indicated she started conducting the infection surveillance and tracking in April of 2025. She was unsure who was conducting the monitoring for infection control prior to April of 2025. An interview conducted with Nurse Consultant 1, on 9/22/25 at 9:00 a.m., indicated the facility was unable to locate any infection surveillance prior to April of 2025. 2. The clinical record for Resident W was reviewed on 9/17/25 at 2:00 p.m. The diagnoses included but were not limited to: heart failure. An observation was conducted of Resident W sitting in her wheelchair in the dining room on 9/17/25 at 2:24 p.m. The resident's PICC was observed missing the needless connector with a dressing dated 9/12/25. An observation was conducted of Resident W's central catheter/PICC with the ADON on 9/17/25 at 2:30 p.m. Resident W had reported to the ADON she had blood drawn that morning, so the lab technician had removed the cap. The ADON indicated it probably was the lab staff that removed the needless connector. She would replace it. 3. On 9/19/25 at 9:43 a.m., the clean linen cart on the Shoreline Hallway was observed to be open to air with the front cover flipped onto the top of the linen cart. The clean linen cart contained a mix of linen and a personal wash basin with two open boxes of facial tissues. There was a urinal on the top shelf of the cart. There were clean incontinent briefs laying scattered on the bottom shelf of the cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/19/25 at 3:09 p.m., the clean linen cart on the Shoreline hallway was observed with the ADON. The clean linen cart contained a mix of linens, an open box of gloves, alcohol hand gel, a wash basin with two open boxes of facial tissue, a urinal, and multiple clean incontinent briefs scattered on the bottom shelf of the cart. The ADON indicated the urinal on the cart was clean, however it was not recommended that personal care items be mixed with the clean linen. A policy entitled Infection Prevention and Control Program, undated, was provided by the ED on 9/17/25 at 12:30 p.m. The policy indicated the Infection Preventionist (IP) coordinates the development and monitoring of the Facility's established infection control policies and procedures. The Facility provides surveillance of Healthcare-Associated Infections (HAIs) and Community-Associated Infections (CAIs) and calculation of infection rates. On 9/22/25 at 9:14 a.m., the Clinical Nurse Consultant provided the Linen Handling Policy and Procedure, effective May 2017, that indicated .It is the policy of this home that staff will handle linens in a manner to prevent the spread of infection . 3.1-18(b)(1)(A) 3.1-18(b)(1)(B) 3.1-18(b)(1)(C)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review, the facility failed to ensure staff remained at bedside while administration of a narcotic medication to a resident as ordered for 1 of 1 random observation of a resident receiving his medications. (Resident X) Findings include: The clinical record for Resident X was reviewed on 9/19/25 at 3:20 p.m. The diagnoses included, but were not limited to, heart failure. The 9/5/25 Quarterly Minimum Data Set assessment indicated Resident X was cognitively intact. A behavior care plan, dated 4/5/24, indicated Resident X had been witnessed holding pain medication in his hand after observation of placing pill in his mouth and drinking water. The interventions included but were not limited to, nurse to observe resident swallowing medication and not pocketing. A physician's order, dated 4/4/24, indicated the staff were to observe the resident swallowing medication due to pocketing. A physician's order, dated 5/19/25, indicated the resident was to receive 10-325 milligrams of Percocet every six hours. The staff were to crush the medication and administer in applesauce. An observation was conducted of Resident X in his bed on 9/17/25 at 11:57 a.m. During an interview with the resident, Registered Nurse (RN) 10 entered the resident's room. RN 10 handed Resident X a medication cup with a yellow crushed pill in applesauce. He then immediately left the resident's room. The resident had reported at that time; the crushed medication was his Percocet medication. He had been accused of selling his narcotic medication, which was untrue, but now he received the narcotic medication crushed. RN 10 should have stayed in the room while he ate it. He then spooned the medication from the cup into his mouth. Resident X's clinical record did not include a self-medication assessment and care plan that indicated the resident was able to safely administer his medications without the presence of the staff. An interview was conducted with the Assistant Director of Nursing (ADON) on 9/19/25 at 11:25 a.m. She indicated Resident X had been caught selling his Percocet medication on the street, so now he received the narcotic medication crushed in applesauce. RN 10 should have remained in the room until the resident had swallowed the medication. A self-administration of medications policy was provided by the Nurse Consultant on 9/22/25 at 8:50 a.m. It indicated, .Any resident who desires to self-administer medication is permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the residents and other residents in the facility 3.1-11(a)

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents' preferences were honored for 2 of 2 residents reviewed for choices. (Resident T and Resident V) 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 10:03 a.m. She indicated the staff have poor communication with the residents. The staff does not know anything about the residents' preferences with care. Resident V had to tell staff how she prefers to be bathed, and how to transfer her in her wheelchair. She reminds them to remove the dirty clothes from her hamper. They just throw wet linen and trash in the hamper with her clothes. Since they do not remove the dirty clothes from the hamper it delays her clothing to be sent to the laundry to be cleaned. She has signage on the bathroom door and verbalizes to the staff her preferences. Resident V's clinical record did not include a completed initial activities/preference assessment. An interview was conducted with the Executive Director on 9/22/25 at 2:50 p.m. She indicated she was unable to locate an activity/preference assessment that had been completed for Resident V. 2. 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). Resident T was admitted to the facility on [DATE]. A Quarterly 8/20/25 MDS assessment indicated Resident T was cognitively intact. The resident's care plan did not include preferences on bathing type and frequency nor getting up or going to bed timeframes. An Activity Initial Assessment for Resident T, dated 1/24/25, indicated it was very important for the resident to choose her bathing type and bedtime. It did not indicate if she preferred showers or bed baths. It was documented as whenever with her preference to get up in the morning and go to bed. An interview was conducted with Resident T on 9/18/25 at 9:18 a.m. She indicated she does have some preferences, but they were not honored by the staff. She would prefer to be showered twice a week. She was unsure how many showers she was supposed to receive. She currently only received one a week; all other bathing was bed baths. Resident T would also prefer to be woken up for the day, at 11:30 a.m., and then put back to bed at 2:30 p.m. She had been told by Certified Nurse Aides (CNAs) that she was not able to be placed back in bed at 2:30 p.m. They were not going to get her up and put her back down on the same shift. She would have to wait to be put back down until second (evening) shift arrived, which would be around 3:00 p.m. to 3:30 p.m. She currently got up, between 12:00 p.m. to 12:30 p.m., and was laid back down around 3:00 p.m. to 3:30 p.m. She agreed to get up later, so she could be laid back down on second shift. That was the timeframe the staff were willing to do for her. She was unable to stay up for long periods of time due to pain. If she can't be laid down by 2:30 p.m., then she will have to get up later to accommodate the staff. The weekends were the worst about getting up and being put back to bed. Sometimes, the staff were unable to get her up at all. She cannot recall being asked by staff what her preferences were with getting up and/or laying down timeframes nor bathing preferences. An activities initial assessment for Resident T, dated 4/27/25, was in the resident's medical record, but it was blank. An interview was conducted with the Assistant Director of Nursing (ADON) on 9/19/25 at 10:29 a.m. She indicated upon admission; the residents' preferences were filled out by the Activities Department. An interview was conducted with the Activities Director (AD) on 9/19/25 at 10:14 a.m. She indicated on a resident's admission she has five days from a resident's admission to speak with the resident about their preferences. Resident V and Resident T were both admitted to the facility prior to her start date in July 2025. August and September 2025 Shower Sheets were provided for Resident T by the ADON on 9/22/25 at 2:00 p.m. It indicated the following days the resident received a bed bath instead of a shower: 8/1/25, 8/15/25, (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/22/25, 8/29/25, 9/3/25, 9/4/25, 9/6/25, 9/10/25, 9/13/25, and 9/18/25.An interview was conducted with CNA 3 on 9/22/25 at 10:40 a.m. She indicated Resident T gets up at around noon and was placed back down by the second shift staff after 3:00 p.m. 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. 3.1-3(u)(3)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on interview and record review, the facility failed to ensure a resident was able to receive personal funds when requested for 1 of 2 residents reviewed for personal funds. (Resident Z)Findings include: The clinical record for Resident Z was reviewed on 9/17/25 at 11:00 a.m. The diagnoses for Resident Z included, but were not limited to, anxiety. The 8/4/25 Quarterly Minimum Data Set (MDS) assessment indicated Resident Z was cognitively intact. An interview was conducted with Resident Z on 9/17/25 at 11:48 a.m. He indicated he was unable to receive his personal funds from the Business Office when he requested $50.00 a couple of weeks ago. The Business Office Manager (BOM) had indicated she was unable to give him any money. An interview was conducted with the BOM on 9/22/25 at 3:07 p.m. She indicated there was a week, or two, the residents were unable to receive their personal funds. The former Executive Director (ED) had abruptly left employment at the facility. The ED was the signer to the checks for the residents' personal funds. Resident Z requested $50.00 a week or two ago, and the BOM was unable to provide the money to him. There was a delay due to the new ED had to receive the approval from the home office to have the ability to become the new signer of the checks for the residents' personal funds. The resident trust fund policy was provided by the ED on 9/22/25 at 3:40 p.m. It indicated, .The Administrator [ED] is responsible for ensuring the establishment and accurate maintenance of the Resident Trust Fund and the related Resident Trust Fund Petty Cash account, including the handling of the funds according to facility policy as well as state and federal regulations.Resident Trust Fund Petty Cash.4. This fund must be available to the resident according to state and federal guidelines, but not less than Monday-Friday during regular office hours.3.1-6(f)(1)

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Castleton Health Care Center	7630 E 86th St Indianapolis, IN 46256

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure a homelike environment for 2 of 4 residents reviewed for homelike environment. (Resident BB and Resident 44)Findings include: 1. An observation was conducted of Resident 44's room on 9/18/25 at 9:25 a.m. There was brown splatter along both closet doors. On 9/19/25 at 10:55 a.m., there continued to be brown splatter along both of Resident 44's closet doors. On 9/22/25 at 3:30 p.m., there continued to be brown splatter along both of Resident 44's closet doors. On 9/22/25 at 3:35 p.m., the Assistant Director of Nursing (ADON) went into Resident 44's room and acknowledged the splatter on Resident 44's closet doors. 2. An observation and interview were conducted with Resident BB in his room on 9/22/25 at 10:50 a.m. He indicated his television doesn't work. He could turn the television on but there was no volume. Resident BB took the remote and demonstrated he was able to turn the television on and off and attempted to increase the volume, but the television remained with no sound. Resident BB indicated he liked watching television and the volume hasn't been working for approximately four to five weeks. An observation and interview were conducted of Resident BB's room with Corporate Nurse 25 on 9/22/25 at 2:10 p.m. Corporate Nurse 25 attempted to take the remote and see if she could get the volume to work on the television, but it was unsuccessful. Corporate Nurse 25 indicated she would have to get the Maintenance Director to see if he could fix the television. Resident BB indicated the Maintenance Director had been in a couple of times and he indicated Resident BB needed a new television. Resident BB indicated if he wanted to watch television and be able to hear it, he would go to one of the common areas and watch the television since he cannot watch the television in his room. The clinical record for Resident BB was reviewed on 9/19/25 at 2:10 p.m. The diagnoses included, but were not limited to, femur fracture, congestive heart failure, diabetes mellitus, and muscle weakness. An admission Minimum Data Set assessment, dated 8/15/25, indicated Resident BB was cognitively intact, had impairment to one side of lower extremities, and indicated it was very important for him to keep up with the news. A policy entitled Policy for a Safe, Homelike Environment, approved date of 4/2025, was provided by the Executive Director on 9/22/25 at 2:28 p.m. The policy indicated to create a comfy, pleasant environment personalized to residents' preferences and needs, allowing them to use their personal belongings where possible. Maintain the building infrastructure (ceilings, walls, floors) in good repair. Provide regular housekeeping and maintenance to maintain cleanliness and orderliness throughout resident and staff areas. 3.1-19(f)(5)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to timely complete a Significant Change of Status Minimum Data Set (MDS) assessment for a resident who discontinued dialysis services for 1 of 2 residents reviewed for dialysis (Resident 2). Findings include: The clinical record for Resident 2 was reviewed on 9/18/25 at 10:15 a.m. The resident's diagnosis included, but were not limited to, diabetes, anxiety disorder, chronic kidney disease, and acute and chronic respiratory failure. A Quarterly MDS assessment, completed 7/26/25, indicated Resident C was cognitively intact and had received dialysis. A physician's order, dated 7/28/25, indicated she was to receive hemodialysis on Monday, Wednesday, and Friday weekly. During an interview on 9/19/25 at 10:32 a.m., Resident 2 indicated she did not receive dialysis anymore. The doctor stopped her dialysis a couple of months ago. During an interview on 9/19/25 at 11:05 a.m., the Transportation Director indicated she had not taken Resident 2 to or from dialysis since she started working at the facility. The Transportation Director began working at the facility in July of 2025. During an interview on 9/19/25 at 2:26 p.m., the Assistant Director of Nursing (ADON) indicated Resident 2's dialysis had officially been discontinued on 7/3/25. Resident 2 had not received dialysis for a week and a half prior to it being officially discontinued. During an interview on 9/19/25 at 2:55 p.m., the Corporate Minimum Data Set Coordinator indicated a Significant Change of Status MDS Assessment should have been completed for Resident 2 after her dialysis was discontinued. The facility used the Resident Assessment Instrument (RAI) manual as the policy for completing MDS assessments. 3.1-31(d)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure care plan meetings were held timely for 1 of 1 resident reviewed for care plan meetings. (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 kidney disease and heart failure. Resident N had the following MDS (Minimum Data Set) Assessments completed: 9/19/24 Admission, 12/27/24 Quarterly, 3/14/25 Quarterly, 6/9/25 Quarterly, and 8/20/25 Quarterly. An interview was conducted with Resident N on 9/17/25 at 12:34 p.m. She indicated she was not having care plan meetings at the facility and was unsure what they were. There were no care plan meeting notes documented in the Miscellaneous or Assessments section of the electronic health record. An interview was conducted with the ED (Executive Director) on 9/22/25 at 1:57 p.m. She indicated they only had verification for two care plan meetings since Resident N's 9/13/24 admission. The last one was held in January of 2025. On 9/22/25 at 1:57 p.m., the ED provided 2 care plan meeting notes. One was dated 10/25/24. The other was dated 1/10/25. The Care Planning policy was provided by the ED on 9/22/25 at 2:28 p.m. It indicated, The Facility will invite the resident, if capable, and their family to care planning meetings and use its best efforts to schedule care planning meetings at times convenient for the resident and family The IDT (Interdisciplinary Team) will revise the Comprehensive Care Plan as needed at the following intervals: A. Per RAI (Resident Assessment Instrument) schedules. 3.1-35(d)(2)(B)

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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. An observation of Resident Q was conducted on 9/18/25 at 10:08 a.m. He had long, unkempt facial hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure catheter care was provided and urine outputs were recorded every shift for 2 of 3 residents reviewed for catheter care. (Resident T and Resident 1) Findings include:1. The clinical record for Resident 1 was reviewed on 9/17/25 at 2:30 p.m. The diagnoses for Resident 1 included, but were not limited to, acute kidney failure and sepsis.An admission Minimum Data Set (MDS) assessment, dated 8/21/25, indicated Resident 1 was cognitively intact. A care plan, dated 8/6/25, indicated Resident 1 had an indwelling catheter due to neurogenic bladder. A physician's order, dated 8/6/25, indicated the resident was to have a 16 French Foley (indwelling) catheter. A physician's order, dated 8/6/25, indicated the resident was to have catheter care completed every shift and as needed.The September 2025 Medication and Treatment Administration Records (MAR/TAR) indicated the resident had received catheter care every shift. An interview was conducted with Resident 1 on 9/17/25 at 2:26 p.m. He indicated the staff does not clean or assess the Foley catheter site daily. They just empty the bag. 2. 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). An 8/20/25 Quarterly MDS assessment indicated Resident T was cognitively intact. A care plan, dated 1/23/25, indicated the resident had an indwelling catheter due to urinary retention and obstructive and reflux uropathy.A physician's order, dated 1/23/25, indicated the staff were to provide catheter care every shift and document urinary output every shift as needed. The September 2025 MAR/TAR indicated the resident was receiving catheter care every shift. The following days and shifts the TAR did not include documented urinary output: 9/3/25 - night shift, 9/5/25 - night shift, 9/6/25 - evening shift,9/7/25 - evening and night shift,9/8/25 - night shift, 9/9/25 - night shift, 9/10/25 - night shift, 9/11/25 - night shift, 9/12/25 - night shift, 9/13/25 - night shift, 9/14/25 - night shift, 9/15/25 - night shift, 9/16/25 - night shift, 9/17/25 - night shift, and 9/18/25 - night shift. An interview was conducted with Resident T on 9/18/25 at 9:21 a.m. She indicated the staff only empty the catheter bag. She was unsure if the staff knew how to properly care for an indwelling catheter. She observed staff lifting the bag above her head as she observed the urine flow from the tube back in her bladder all the time. They do not clean the catheter site unless she has a bowel movement. An observation was conducted of Resident T in her bed on 9/22/25 at 10:17 a.m. During that time, Resident T had requested Registered Nurse (RN) 10 to empty her catheter bag due to it being full of urine. RN 10 emptied the catheter bag. He then left the room. The resident at that time, reported that RN 10 did not provide any cleansing of the catheter site. An observation was conducted of Resident T being provided catheter care by Certified Nurse Aide (CNA) 3 on 9/22/25 at 10:39 a.m. CNA 3 was observed washing her hands and donning on a gown and gloves. After, she picked up a urinal and drained the resident's urinary catheter bag. She then doffed her gown and gloves, utilized hand hygiene, and left the room. An interview was conducted with CNA 3 on 9/22/25 at 10:40 a.m. She indicated she provides catheter care, that included cleansing the catheter site, when the resident had a bowel movement or during bathing. An interview was conducted with Assistant Director of Nursing (ADON) and the Nurse Consultant on 9/22/25 at 10:45 a.m. They indicated the staff should be providing catheter care consisting of cleansing of the catheter site and documenting urinary outputs every shift. A list of all residents that have catheters in the building was provided by the Executive Director on 9/22/25 at 12:47 p.m. It indicated the facility had nine residents in the building with urinary catheters. A catheter care policy was provided by the ADON on 9/22/25 at 11:20 a.m. It indicated, Purpose: To prevent catheter-associated urinary tract infections while ensuring that residents are not given indwelling catheters unless medically necessary.Procedure. I. Daily Catheter Care.E. Cleanse the perineum from front to back and cleanse the outside of the catheter wiping away from the meatus.K. Record urinary output. 3.1-41(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure oxygen therapy was delivered to a resident, as ordered by the physician, and to ensure a resident who was receiving oxygen therapy had a physician's order for oxygen for 2 of 5 residents reviewed for oxygen therapy. (Resident 2 and Resident 55)Findings include: 1. The clinical record for Resident 2 was reviewed on 9/18/25 at 10:15 a.m. The resident's diagnoses included, but were not limited to, diabetes, anxiety disorder, chronic kidney disease, and respiratory failure. A physician's order, dated 12/20/24, indicated she was to receive oxygen at one liter a minute via nasal cannula each shift. A Quarterly Minimum Data Set (MDS) assessment, completed 7/26/25, indicated Resident C was cognitively intact and received oxygen therapy. During an interview on 9/19/25 at 10:32 a.m., Resident 2 indicated she did not use her oxygen all the time. She wore it mostly at night when she needed it. She hasn't utilized oxygen at all times for a while. She was not wearing oxygen at the time of the interview. On 9/22/25 at 10:37 a.m., Resident 2 was observed in her room sitting in her wheelchair. She was not wearing oxygen. The September 2025 Treatment Administration Record (TAR) indicated Resident 2 had received one liter of oxygen via nasal cannula each shift with the exception of 9/1/25 - evening shift, 9/8/25 - day shift, 9/9/25 - day shift, and 9/17/25 - day shift. During an interview on 9/22/25 at 3:23 p.m., the Clinical Nurse Consultant indicated Resident 2 should have oxygen applied as ordered. She was unsure why Resident 2 was not wearing her oxygen. 2. The clinical record for Resident 55 was reviewed on 9/17/25 at 3:00 p.m. The diagnoses for Resident 55 included, but were not limited to, cirrhosis of liver. A care plan, dated 9/16/25, indicated Resident 55 received hospice services. A care plan, initiated 9/18/25, indicated the resident received oxygen therapy. An observation was conducted of Resident 55 in his bed on 9/17/25 at 3:10 p.m. The resident was observed in his bed with his eyes closed. An oxygen concentrator was running at the bedside. The resident was receiving 3.5 liters of oxygen via a nasal cannula (tubing in nose). During that time, Registered Nurse (RN) 10 walked into the resident's room. RN 10 was observed speaking to the resident at bedside. An observation was conducted of Resident 55 on 9/18/25 at 1:07 p.m. The resident was observed in bed with his eyes closed. The resident's oxygen concentrator was observed running. Resident 55 was receiving 3.5 liters of oxygen via nasal cannula. Resident 55's clinical record did not have physician orders in place to receive oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Nurse Consultant on 9/18/25 at 2:07 p.m. She indicated the hospice staff had placed the oxygen on Resident 55. She would get physician orders at that time. An oxygen administration policy was provided by the Nurse Consultant on 9/22/25 at 8:50 a.m. It indicated, .A physician's order is required to initiated oxygen therapy.C. A physician is to be contacted as soon as possible after initiation of oxygen therapy in emergency situations, for verification and documentation of the order for oxygen therapy consultation, and further orders. 3.1-47(a)(6)

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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. 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. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Resident BB's electronic clinical record and indicated she was unable to locate any verification of vital signs or non-pharmacological interventions attempted for his PRN pain medication administrations. The Pain Management policy was provided by the ED (Executive Director) on 9/22/25 at 11:30 a.m. It indicated, The Licensed Nurse will administer pain medication as ordered and document medication administered on the Medication Administration Record (MAR) .Nursing Staff will implement timely interventions to reduce the increase in severity of pain .Nursing Staff will also utilize non-pharmacological interventions by adjusting the resident's environment to reduce pain. This citation relates to Intake 2613777. 3.1-37(a)

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	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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident on dialysis received pre/post assessments that included vital signs and obtaining weights that were consistent and documentation of dialysis refusals and confirmed dialysis appointments were included in the electronic health record (EHR) for 1 of 1 resident reviewed for death. (Resident P)Findings include: The clinical record for Resident P was reviewed on 9/22/25 at 9:43 a.m. The diagnoses included, but were not limited to, end stage renal disease, type one diabetes mellitus, epilepsy (seizure disorder), congestive heart failure, noncompliance with other medical treatment, and muscle weakness. A Quarterly Minimum Data Set (MDS) assessment, dated 6/10/25, indicated Resident P received dialysis and was cognitively intact. An Annual MDS assessment, dated 8/27/25, indicated Resident P was cognitively intact and experienced rejection of care behavior. A care plan for dialysis, initiated on 8/28/24 and revised on 9/16/25, indicated Resident P needed hemodialysis related to end stage renal disease. Resident P was noncompliant with dialysis. The interventions included, but were not limited to, encourage resident to go to scheduled dialysis appointments on Tuesday, Thursday, and Saturday. A physician's order, revised 3/12/25, indicated Resident P received dialysis at the dialysis center on Tuesday, Thursday, and Saturday at 11:40 a.m. Staff were to complete the pre/post dialysis assessment on Tuesday, Thursday, and Saturday. A physician's order, dated 3/19/25, indicated to open and complete dialysis communication every Tuesday, Thursday, and Saturday. A fluid volume care plan, revised 9/16/25, indicated the potential for fluid volume overload related to end stage renal disease. The interventions included, but were not limited to, monitoring vital signs as ordered and record. A dialysis communication form, dated 8/5/25, consisted of vital signs on the post-dialysis documentation retrieved from 7/15/25, 8/4/25, and 8/5/25 in the morning. A dialysis communication form, dated 8/7/25, consisted of no vital signs documented on the pre-dialysis documentation nor the post-dialysis documentation. There were no dialysis communication forms completed for 8/9/25. The progress notes did not indicate Resident P refused dialysis. Resident P refused dialysis on 8/12/25. There were no dialysis communication forms completed for 8/14/25. The progress notes did not indicate Resident P refused dialysis. Resident P refused dialysis on 8/16/25. There were no dialysis communication forms completed for 8/19/25. The progress notes did not indicate Resident P refused dialysis. Resident P was hospitalized from [DATE] to 8/26/25. Resident P refused dialysis on 8/28/25. There were no dialysis communication forms completed for 8/30/25. The progress notes did not indicate Resident P refused dialysis. A dialysis communication form, dated 9/2/25, consisted of no vital signs documented under the post-dialysis documentation. Resident P refused dialysis on 9/4/25. A dialysis communication form, dated 9/6/25, consisted of vital signs on the post-dialysis documentation retrieved from 9/2/25 and 9/3/25 and notes that stated resident loa dialysis at this time under the notes of the post-dialysis documentation. A dialysis communication form, dated 9/9/25, consisted of vital signs on the pre and post-dialysis documentation retrieved from 9/4/25, 9/6/25, 9/7/25, and 9/8/25. A dialysis communication form, dated 9/11/25, consisted of vital signs on the pre and post-dialysis documentation retrieved from 9/4/25, 9/6/25, 9/7/25, and 9/10/25. A dialysis communication form, dated 9/13/25, consisted of vital signs on the pre and post-dialysis documentation retrieved from 9/13/25. A document titled Hemodialysis Treatment was provided by the ED on 9/23/25 at 8:45 a.m. The documents were labeled with the dialysis company and location where Resident P went and received hemodialysis. The documentation indicated Resident P's most recent hemodialysis treatment at the dialysis facility was on 9/6/25. There were no progress notes, dated 9/9/25, 9/11/25, and 9/13/25 that indicated Resident P refused dialysis. An interview conducted with Nurse Practitioner (NP) 8, on 9/23/25 at 10:00 a.m., indicated Resident P refused dialysis treatments on an ongoing basis. NP 8 would attempt to visit Resident P, but the resident would refuse to be seen by NP 8 or the Physician. NP 8 indicated that the nursing staff would make (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him aware of Resident P refusing dialysis and Resident P did refuse dialysis often before he passed away on 9/16/25. There were times when Resident P didn't want to take medications and refused vital signs to be obtained. So, there was a barrier to the management in Resident P's care. A policy entitled Dialysis Care, revised 6/2020, was provided by the Executive Director on 9/22/25 at 1:57 p.m. The policy indicated the Facility will provide a method of communication between the dialysis provider and the Facility. The Facility will be responsible for the overall care delivered to the resident, monitoring the resident prior to and after the completion of each dialysis treatment, and providing for all non-dialysis needs of the resident, including during the time period when the resident was receiving dialysis. All documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident's medical record. 3.1-37(a)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure ancillary services were consented to and provided timely for 2 of 2 residents reviewed for dental services and 1 of 2 residents reviewed for vision services (Resident T and Resident R). Findings include: 1. 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). Resident T was admitted to the facility on [DATE]. An 8/20/25 Quarterly Minimum Data Set (MDS) assessment indicated Resident T was cognitively intact. An interview was conducted with Resident T on 9/18/25 at 9:37 a.m. She indicated she would like to see an eye doctor and a dentist. She has been asking to see the eye doctor but still had not heard anything. A resident's ancillary consent was provided by the Executive Director on 9/22/25 at 11:26 a.m. It indicated the resident filled out in September she would like to receive vision and dental services. An interview was conducted with the Executive Director on 9/22/25 at 12:30 p.m. She indicated she was unable to locate any ancillary consents for Resident T that the resident declined or wished to have ancillary services, so she had her fill out an ancillary consent form. She has not been seen by a dentist nor eye doctor. 2. The clinical record for Resident R was reviewed on 9/18/25 at 10:40 a.m. His diagnoses included, but were not limited to, type 2 diabetes. He was admitted to the facility on [DATE]. The 7/24/25 Significant Change MDS assessment indicated he was cognitively intact. An interview was conducted with Resident R on 9/18/25 at 10:48 a.m. He indicated he hadn't seen a dentist in the facility, and he needed his teeth cleaned. There were no dental consents, orders, or consultation notes in Resident R's clinical record. An interview was conducted with the ED (Executive Director) and NC (Nurse Consultant) 1 on 9/19/25 at 10:38 a.m. The ED indicated the process for a resident to be seen by their dental provider was to obtain dental consent from the resident upon admission. They would then be placed on the list to be seen at the dentist's next visit. Their dentist was here last week. An interview was conducted with the SSD (Social Services Director) via telephone in the presence of the ED and NC 1 on 9/19/25 at 10:38 a.m. She indicated she'd only worked at the facility since 8/11/25. Within the first week of a resident's admission, she asked them or their representative if they wanted to be seen by the facility's dentist or an outside dentist. If the facility's dentist was chosen, the resident would be placed on the list to be seen for an initial evaluation. All dental consent forms should be in the electronic health record and a binder in her office. She was unsure about Resident R's dental consent, as he was admitted prior to her employment at the facility. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the MRC (Medical Records Coordinator) on 9/19/25 at 12:20 p.m. She indicated she called their dental provider. Resident R was not on their caseload, and they never received a consent form for him to be seen. They never found any verification he denied or consented to dental services in the facility. On 9/22/25 at 8:50 a.m., NC 1 provided a blank dental consent form. There was a section to check whether a resident without Medicaid consented to dental care, wanted contacted about non-covered services, or declined dental services. The Dental Policy and Procedure was provided by NC 1 on 9/19/25 at 1:00 p.m. It indicated, Residents have the right to access dental care, including preventive and restorative services .Preventive Care: Regular oral examinations, cleanings, and fluoride treatments will be scheduled in consultation with dental providers .Staff will assist in scheduling dental appointments and provide transportation as needed. 3.1-34(a)(1)

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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 observation and record review, the facility failed to ensure a system of records for facility staff signing-on and signing-off regarding controlled medications being accounted for was maintained regarding 3 of 5 narcotic logs reviewed. (Facility)Findings include: An observation was conducted of three medication carts that contained a narcotic log/binder. Two medication carts were located on Sunset and Shoreline hallways, and the third log was located on the medication cart on the rehabilitation hallway. The following was noted: One cart had a count sheet form dated 9/16/25 to 9/22/25. There were three instances where staff did not sign-in or sign-out from their shift to indicate if there were cards of narcotics added, removed, and/or the total number of narcotic medication cards in the narcotic box of the medication cart. One cart had a count sheet form dated 9/1/25 to 9/22/25. There were seven instances where staff did not sign-in or sign-out from their shift to indicate there were cards of narcotics added, removed, and/or the total number of narcotic medication cards in the narcotic box of the medication cart. A policy entitled Medication - Administration, undated, was provided by Nurse Consultant 1 on 9/18/25 at 12:48 p.m. The policy indicated to provide practice standards for safe administration of medications for residents in the Facility. 3.1-25(e)(2)3.1-25(e)(3)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician included rationales for declining pharmacy recommendations for 1 of 5 residents reviewed for unnecessary medications. (Resident 2)Findings include: The clinical record for Resident 2 was reviewed on [DATE] at 10:15 a.m. The resident's diagnoses included, but were not limited to, diabetes, anxiety disorder, chronic kidney disease, and acute and chronic respiratory failure. Physician's orders, dated [DATE], indicated she was to receive atorvastatin calcium 20 milligram (mg); one tablet daily by mouth at bedtime, dicyclomine hydrochloride (antispasmodic) 20 mg by mouth twice daily, and pantoprazole sodium (gastric acid reducer) 20 mg by mouth each morning. A physician's order, dated [DATE], indicated she was to receive trazodone (anti-depressant) 50 mg by mouth at bedtime for insomnia. A physician's order, dated [DATE], indicated she was to receive hydrocodone- acetaminophen (narcotic pain medication) 7.5- 325 mg; one tablet by mouth every six hours as needed for pain. A physician's order, dated [DATE], indicated she was to receive apixaban (blood thinner) 5 mg by mouth twice daily. A Medication Regimen Review, dated [DATE], indicated Resident 2 had received trazodone 50 mg every evening since [DATE]. Patients receiving antidepressant medication being used for insomnia should be reviewed at least quarterly for gradual dose reductions to determine if the resident's symptoms can be controlled on a lower dose or without the medications. The recommendation was to please consider reducing the dose to 25 mg each bedtime. The Physician Response Section had Disagree selected. There was no clinical rationale offered for why the Physician disagreed with the recommendation. A Medication Regimen Review, dated [DATE], indicated the following medications had recommendations: 1. A current order for apixaban 5 mg twice a day. This was a medication that was recommended to have a renal adjusted dose. The recommendation was to consider discontinuing the apixaban if clinically appropriate. 2. Hydrocodone-acetaminophen 7.5-325 mg every 6 hours as needed for pain had not been used since it was started in [DATE]. The recommendation was to re-evaluate and consider the possibility of discontinuing, unless there was a valid clinical indication for prolonged use. 3. Atorvastatin 20 mg each bedtime. Resident 2's recent lipid panel results were listed and the recommendation was to consider reducing the dose to 10 mg each bedtime, if clinically appropriate. 4. Dicyclomine 20 mg twice daily for abdominal pain since [DATE]. The medication was intended for short-term use. Scheduled dosing for greater than 2 weeks had not been studied. The recommendation was to please consider discontinuing the dicyclomine. 5. Pantoprazole 20 mg each morning since [DATE]. The recommendation was to consider tapering down every two weeks, then changing the pantoprazole to as needed for two weeks and discontinuing if not used. The Physician Response Section had disagreed selected with no clinical rational included. The third page of the Medication Regimen Review had still needed handwritten on the page. During an interview on [DATE] at 3:23 p.m., the Clinical Nurse Consultant indicated she was unsure what the still needed written on the third page meant. A rationale should have been provided if the recommendation was disagreed with by the practitioner. During an interview on [DATE] at 2:09 p.m., the Director of Nursing indicated the Nurse Practitioner who had completed the Medication Regimen Review forms was new and unsure of exactly how to fill out the forms. 3.1-25(i)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to administer a resident's medication as ordered that resulted in a resident receiving their medication in an excessive dosage for 1 of 5 residents reviewed for unnecessary medications. (Resident 68) Findings include: The clinical record for Resident 68 was reviewed on 9/23/25 at 9:49 a.m. Her diagnoses included, but were not limited to, insomnia.The physician's orders indicated to administer one 3 mg tablet of melatonin by mouth in the evening for insomnia, effective 1/6/25. There was another order to administer one 3 mg tablet of melatonin by mouth at bedtime for sleep, effective 7/28/24.The September 2025 MAR (medication administration record) indicated she received the 3 mg tablet of Melatonin at 8:00 p.m. and 9:00 p.m. daily, for a total of 6 mg per day. The Assessment/Plan sections of the 8/13/25 and 9/19/25 psychiatry progress notes indicated to continue melatonin 3 mg every evening for sleep disorder.The 8/19/25 pharmacy note to the facility indicated there were two orders for melatonin and to please discontinue one. This note was signed by NP (Nurse Practitioner) 8.An interview was conducted with NP 8 on 9/23/25 at 11:00 a.m. He indicated he signed the above pharmacy recommendation on 9/3/25, but the facility did not discontinue one of the melatonin orders, as they should have.The Policy on Unnecessary Medications was provided by the ED (Executive Director) on 9/23/25 at 1:20 p.m. It indicated, Purpose: To ensure that residents receive only those medications that are medically necessary for their health and well-being, in accordance with F757 regulatory compliance, thereby promoting optimal health outcomes and minimizing the risks associated with polypharmacy.Definition: Unnecessary Medications: Medications that are not clinically justified, include excessive doses, are not indicated based on the resident's diagnosis, or have not been appropriately monitored for effectiveness or side effects.3.1-48(a)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure tube feeding was stopped prior and after an anticonvulsant medication was administered as ordered for 1 of 1 resident reviewed for tube feeding. (Resident 4)Findings include:The clinical record for Resident 4 was reviewed on 9/23/25 at 11:00 a.m. The diagnoses for Resident 4 included, but were not limited to, seizures. A physician's order, dated 5/4/25, indicated the resident was to receive two tablets of 100 milligrams of phenytoin sodium (Dilantin) at 8:00 p.m. A physician's order, dated 7/29/25, indicated the resident was to receive 1.5 Jevity enteral feeding at 75 milliliters an hour for 10 hours a day with 55 milliliters of water flushes. The feeding was scheduled to start at 6:00 p.m. and stopped at 4:00 a.m. The staff were to hold the feeding for two hours before and two hours after the administration of the Dilantin. The order was changed on 9/16/25. A physician's order, dated 9/16/25, indicated the resident was to receive 1.5 Jevity enteral feeding at 65 milliliters an hour for 10 hours a day with 55 milliliters of water flushes. The feeding was scheduled to start at 6:00 p.m. and stopped at 4:00 a.m. The staff were to hold the feeding for two hours before and two hours after the administration of the Dilantin. A physician's order, dated 6/10/25, indicated the staff was to hold the 1.5 Jevity enteral feeding for Activities of Daily Living care, medication administration, gut rest, activities and at the resident's request up to four hours a day. The staff was to document how long in minutes/hours the tube feeding was turned off. The September 2025 Medication Administration Record (MAR) indicated Resident 4 received the Dilantin at 8:00 p.m., daily on 9/2/25 through 9/20/25 and 9/22/25. The resident received his 1.5 Jevity enteral feeding at 75 milliliters and hour on the following days: 9/1/25, 9/2/25, 9/3/25, 9/4/25, 9/6/25, 9/8/25, 9/9/25, 9/10/25, 9/11/25, 9/12/25, 9/13/25, 9/14/25, and 9/15/25. Resident 4 received the 1.5 Jevity at 65 milliliters and hour on the following days: 9/16/25, 9/17/25, 9/18/25, 9/19/25, 9/20/25, and 9/22/25. The MAR did not indicate the resident's tube feeding was stopped for two hours prior to the administration of the Dilantin nor was it stopped two hours after the administration of the Dilantin as ordered. An interview was conducted with the Executive Director on 9/23/25 at 1:46 p.m. She indicated she did not know why the staff did not hold the tube feeding for two hours prior to or after the administration of the Dilantin. 3.1-48(c)(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure residents medical records were accurately documented for 2 of 5 residents reviewed for unnecessary medications. (Resident V and Resident 2) 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. A physician's order, dated 7/17/25, indicated Resident V was to receive 150 milligrams of bupropion (antidepressant) in the evenings. The medication was changed on 8/6/25. A physician's order, dated 8/6/25, indicated Resident V was to receive 1.5 tablets, total dosage of 225 milligrams, of bupropion daily. A physician's order, dated 8/25/25, indicated Resident V was to receive 300 milligrams of bupropion daily. The August 2025 Medication Administration Record (MAR) indicated the following days Resident V did receive 1.5 tablets that equaled 225 milligrams of bupropion: 8/10/25, 8/12/25, 8/13/25, 8/15/25, 8/19/25, 8/23/25, and 8/24/25. An interview was conducted with the Executive Director (ED), the Nurse Consultant (NC) and the Director of Nursing (DON) on 9/23/25 at 9:21 a.m. They indicated Resident V was taking 150 milligrams of bupropion as of 7/17/25. The medical provider had increased the resident's dosage to 1.5 tablets totaling 225 milligrams of bupropion daily on 8/6/25. The pharmacy had not notified the facility until 8/11/25; the medication was unable to come in as half tablets. They could not supply the 1.5 tablets. The staff that documented the 1.5 tablets of bupropion was administered must have been administering 1 tablet of 150 milligrams of bupropion, because the dosage ordered could not be filled by the pharmacy. 2. The clinical record for Resident 2 was reviewed on 9/18/25 at 10:15 a.m. The resident's diagnoses included, but were not limited to, diabetes, anxiety disorder, chronic kidney disease, and respiratory failure. A Quarterly Minimum Data Set assessment, completed 7/26/25, indicated that Resident 2 was cognitively intact and received dialysis. A physician's order, dated 7/28/25, indicated she was to receive hemodialysis on Monday, Wednesday, and Friday weekly. During an interview on 9/19/25 at 10:32 a.m., Resident 2 indicated she did not receive dialysis anymore. The doctor had stopped her dialysis a couple of months ago. During an interview on 9/19/25 at 2:26 p.m., the Assistant Director of Nursing (ADON) indicated Resident 2's dialysis had officially been discontinued on 7/3/25. Resident 2 had not received dialysis for a week and a half prior to it being officially discontinued. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The August 2025 Medication Administration Record (MAR) contained documentation that she had received hemodialysis on the following days: 8/1/25, 8/4/25, 8/6/25, 8/8/25, 8/11/25, 8/13/25, and 8/15/25. On 9/22/25 at 1:57 p.m., the Executive Director provided the Medical Record Content Policy, last revised June 2020, which indicated .To ensure adequate and accurate documentation of care provided to each resident while at the Facility . The Facility will maintain a medical record for each resident admitted to the Facility that will contain sufficient information to identify the resident, support the diagnosis, justify the medical necessity for treatment, and facilitate continuity of care among health care providers . 3.1-50(a)(2)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to ensure influenza and pneumococcal immunizations were offered and administered upon consent for approval for 3 of 5 residents reviewed for immunizations. (Resident 7, Resident 9, and Resident 35)Findings include: 1. The clinical record for Resident 35 was reviewed on 9/19/25 at 10:30 a.m. A current physician's order, dated 6/25/24, indicated Resident 35 could receive the pneumonia vaccination unless contraindicated. An immunization informed consent document, dated 4/13/25, indicated Resident 35 consented to receive the pneumococcal immunization. The immunization tab within the electronic health record (EHR) indicated the last pneumococcal immunization was historical and last administered on 10/8/1999 as Pneumovax Dose 1. 2. The clinical record for Resident 7 was reviewed on 9/19/25 at 10:40 a.m. The diagnoses included, but were not limited to, asthma. A current physician's order, dated 8/28/25, indicated Resident 7 could receive the pneumonia vaccination and influenza vaccination unless contraindicated. An immunization informed consent document, dated 4/14/25, indicated Resident 7 consented to receive the pneumococcal immunization and the influenza immunization. The immunization tab within the EHR indicated the last pneumococcal immunization was historical and last administered on 5/22/18 as Prevnar 13. 3. The clinical record for Resident 9 was reviewed on 9/19/25 at 10:45 a.m. An immunization informed consent document, dated 11/24/24, indicated Resident 9 consented for the influenza immunization. A current physician's order, dated 12/21/24, indicated Resident 9 could receive the influenza immunization annually. The immunization tab within the EHR indicated the last influenza immunization was administered on 11/28/23. An interview conducted with the Assistant Director of Nursing (ADON), on 9/19/25 at 11:24 a.m., indicated the consent forms are obtained on an annual basis and the facility administers the immunizations the residents consented to. The ADON provided documents for Resident 7, Resident 9, and Resident 35 that indicated they all consented to receiving the influenza and pneumococcal immunization but there were no dates on the documents. A policy entitled Pneumococcal Disease Prevention, undated, was provided by the Executive Director (ED) on 9/17/25 at 1:36 p.m. The policy indicated the pneumococcal immunization was recommended for residents of nursing homes or long-term care facilities. A policy entitled Influenza Prevention & Control, revised 6/2020, was provided by the ED on 9/19/25 at 12:06 p.m. The policy indicated residents were offered annual influenza immunizations during flu season annually. 3.1-13(a)