

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER Waters of Castleton Skilled Nursing Facility, The		STREET ADDRESS, CITY, STATE, ZIP CODE 8400 Clearvista Pl 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>36942</p> <p>Based on observation, interview, and record review, the facility failed to ensure a fall intervention was implemented timely after a fall event occurred and fall interventions were in place for 1 of 3 residents reviewed for accidents. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 4/16/25 at 11:30 a.m. The diagnoses included, but were not limited to, borderline personality disorder, bipolar disorder, schizoaffective disorder, generalized anxiety disorder, and major depressive disorder.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 4/9/25, indicated Resident D was moderately cognitively impaired and had two or more falls since the last MDS assessment.</p> <p>A care plan, revised 4/14/25, indicated Resident D was at risk for falls related to incontinence and psychoactive drug use. The interventions included, but were not limited to, anti-roll backs to the wheelchair, initiated on 4/14/25, and encourage the resident to wear nonskid footwear and/or nonskid socks, initiated on 3/11/25.</p> <p>A progress note, dated 4/13/25 at 10:46 p.m., indicated Resident D was observed sitting on the floor facing her bed. Resident D stated she was trying to move herself from the wheelchair to the bed and lost her balance and slipped to the floor.</p> <p>An observation was conducted of Resident D, on 4/16/25 at 12:42 p.m., of her sitting in a wheelchair that didn't have anti-roll backs present. Resident D was interviewed, and she stated she was upset because the facility staff took the wheelchair she was previously using and provided her with another one that she didn't like. Resident D didn't understand why her wheelchair was switched out. The Assistant Director of Nursing (ADON) was present and indicated the maintenance staff came and took Resident D's wheelchair to apply the anti-roll backs to the wheelchair. Resident D remained upset and stated she didn't want to eat lunch and wanted to lay herself back in bed. The ADON attempted to assist Resident D while she was transferring herself from the wheelchair to the bed, but Resident D refused any assistance and stated she could transfer herself. Resident D was wearing fluffy socks that were not nonskid socks while she was transferring herself from the wheelchair to the bed.</p> <p>This citation relates to Complaint IN00457282.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3.1-45(a)(2)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942</p> <p>Based on interview and record review, the facility failed to ensure narcotic medication was administered per the physician orders, narcotic medication was readily available for use, and intravenous (IV) antibiotics were obtained to be administered as ordered by the physician for 2 of 3 residents reviewed for medication use. (Resident C and Resident D)</p> <p>Findings include:</p> <p>1a. The clinical record for Resident C was reviewed on 4/16/25 at 10:47 a.m. The diagnoses included, but were not limited to, osteomyelitis (infection of bone), pressure ulcer of sacral region, paraplegia, and muscle spasm. Resident C was admitted to the facility on [DATE].</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 3/6/25, indicated Resident C was cognitively intact, had one injection, utilized antianxiety medication, antibiotic medication, and opioid medication.</p> <p>A care plan for IV medications, revised 3/7/25, indicated Resident C was on IV antibiotics related to osteomyelitis.</p> <p>A physician order, dated 2/28/25, indicated to administer three grams of ceftolozane-tazobactam (antibiotic) IV; three times a day for infection until 3/7/25. The order was discontinued on 3/1/25.</p> <p>The February 2025 electronic medication administration record (EMAR) indicated Resident C did not receive the IV antibiotic for the three scheduled administrations on 2/28/25.</p> <p>A progress note, dated 2/28/25 at 9:17 a.m., indicated the IV antibiotic was unavailable for administration.</p> <p>A progress note, dated 2/28/25 at 2:38 p.m., indicated the IV antibiotic was unavailable for administration.</p> <p>A physician order, dated 3/1/25, indicated to administer three grams of ceftolozane-tazobactam IV; three times a day for infection until 3/8/25. The order was discontinued on 3/7/25.</p> <p>The March 2025 EMAR indicated Resident C did not receive the IV antibiotic on the following date(s)/time(s):</p> <ul style="list-style-type: none"> - 3/1/25 at 9:00 a.m., - 3/1/25 at 1:00 p.m., - 3/5/25 at 9:00 a.m., - 3/5/25 at 1:00 p.m., and <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 3/6/25 at 9:00 a.m.</p> <p>A progress note, dated 3/1/25 at 12:58 p.m., indicated the IV antibiotic was on order and not available for administration.</p> <p>A progress note, dated 3/5/25 at 12:22 p.m., indicated the IV antibiotic was on hold due to the IV site being infiltrated (complication of intravenous therapy, with the administered medication or fluid leaking into the surrounding tissues; that occurs when the IV catheter dislodged, punctures the vein, or is not secured properly).</p> <p>1b. A care plan, dated 2/28/25, indicated Resident C was on psychoactive medications to treat anxiety. The interventions included, but were not limited to, administering psychoactive medications as ordered.</p> <p>A physician order, dated 2/28/25, indicated to administer pregabalin (drug used to treat epilepsy, nerve pain and anxiety) 75 milligrams (mg) two times a day for neuropathy pain (damage, disease, or dysfunction of one or more nerves).</p> <p>The February 2025 EMAR indicated Resident C was not administered the pregabalin 75 mg on 2/28/25.</p> <p>The March 2025 EMAR indicated Resident C was not administered the pregabalin 75 mg on the following date(s)/time(s):</p> <p>- 3/1/25 in the morning and evening,</p> <p>- 3/2/25 in the evening,</p> <p>- 3/3/25 in the evening, and</p> <p>- 3/4/25 in the morning and evening.</p> <p>A progress note, dated 3/1/25 at 12:21 p.m., indicated the pregabalin 75 mg was on order from the pharmacy.</p> <p>A progress note, dated 3/2/25 at 4:14 p.m., indicated the pregabalin 75 mg was not available and the pharmacy was notified.</p> <p>A progress note, dated 3/3/25 at 7:45 a.m., indicated the pregabalin 75 mg was not available.</p> <p>A progress note, dated 3/4/25 at 1:28 p.m., indicated the pregabalin 75 mg was not available.</p> <p>A controlled drug receipt/record/disposition form indicated Resident C's pregabalin 75 mg, quantity of 12, was received on 3/4/25. The first administration of the pregabalin 75 mg was on 3/5/25 at 9:00 a.m.</p> <p>An interview conducted with the Director of Nursing (DON), on 4/16/25 at 4:08 p.m., indicated there were no other narcotic sheets for Resident C's pregabalin medication prior to 3/4/25. The DON was unsure why the pregabalin medication did not arrive prior to 3/4/25.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. The clinical record for Resident D was reviewed on 4/16/25 at 11:30 a.m. The diagnoses included, but were not limited to, borderline personality disorder, bipolar disorder, schizoaffective disorder, generalized anxiety disorder, and major depressive disorder.</p> <p>A care plan, revised 1/17/25, indicated Resident D was prescribed psychoactive medication to treat the diagnosis of anxiety. The interventions included, but were not limited to, administering psychoactive medications as ordered.</p> <p>A physician order, dated 12/5/24, was noted for clonazepam (benzodiazepine/antianxiety medication) 0.5 mg one time a day at bedtime for schizoaffective disorder.</p> <p>The controlled drug record forms were reviewed and indicated the following date(s) to where there was no controlled drug record form to resemble a lapse in medication administration for Resident D's clonazepam:</p> <p>12/27/24 to 12/31/24,</p> <p>1/16/25 to 1/18/25, and</p> <p>2/5/24 to 2/11/25.</p> <p>The controlled drug record forms indicated the following instances where the clonazepam was not signed off, as administered, daily:</p> <p>- 3/25/25,</p> <p>- 3/30/25, and</p> <p>- 4/10/25.</p> <p>A policy entitled Medication Administration, dated March 2023, was provided by the DON on 4/16/25 at 2:05 p.m. The policy indicated if a medication was ordered but not present, to contact the pharmacy or supervisor to obtain the medication.</p> <p>This citation relates to Complaint IN00457282.</p> <p>3.1-25(a)</p> <p>3.1-25(g)(3)</p>		