STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155271	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Castleton Skilled Nursing Facility, The	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)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer a resident's antipsychotic medication, as ordered; inform the physician/provider of the medication not having been administered; and implement and revise a resident's behavior care plan regarding refusal of care and medication for 1 of 3 residents reviewed for behavioral Health Services. (Resident B)Findings include:The clinical record for Resident B was reviewed on 10/28/25 at 2:42 p.m. His diagnoses included, but were not limited to: anxiety, paranoid schizophrenia, dementia, and depression. He was readmitted to the facility on [DATE] after a 20-day inpatient psychiatric hospitalization. The Inpatient Psychiatric Hospital Discharge Medication Reconciliation, dated 9/23/25, indicated staff were to administer the resident's Uzedy (atypical antipsychotic medication) 75 mg/0.21ml subcutaneously every 30 days at 9:00 am. His last administration was on 9/18/25 at 9:59 a.m.The facility physician's orders indicated to administer the above order for Uzedy, starting 10/16/25, for psychosis.The care plan, dated 9/24/25, indicated the resident was prescribed psychoactive medication to treat the diagnosis of psychosis. An intervention was to administer his medication as ordered. The October, 2025 medication administration record (MAR) indicated the resident's Uzedy was not administered on 10/16/25 with a link to a note, written by LPN (Licensed Practical Nurse) 2. The note indicated, Note Text: Uzedy Subcutaneous Suspension Prefilled Syringe 75 MG/0.21ML Inject 0.21 ml subcutaneously one time a day every 30 day(s) for psychosis. Reordered, medication is not available.An interview was conducted with the DON (Director of Nursing) on 10/28/25 at 10:42 a.m. He reviewed Resident B's clinical record and indicated he saw the nurse's note that the Uzedy was unavailable on 10/16/25, and the MAR indicated it was not given in the month of October, 2025. He did not see any documentation that the physician was notified the Uzedy was not administered, as ordered, but they should have been. If the medication was unavailable for administration on 10/16/25, nursing should have reordered the medication and administered it upon arrival.An interview was conducted with Pharmacy Technician 3 in the presence of the DON on 10/28/25 at 10:48 a.m. He indicated they first received a request from the facility for the Uzedy in September, 2025 and it was delivered to the facility on 9/23/25. The second delivery of Uzedy to the facility was delivered on 10/20/25. The medication had to be requested for each administration.On 10/28/25 at 11:00 a.m., an observation of the medication refrigerator was made with the DON and LPN 2, who signed off the Uzedy as unavailable on 10/16/25. There were two unopened boxes of Uzedy available for administration in the refrigerator. One had a delivery date of 9/23/25, and the other had a delivery date of 10/20/25. These delivery dates matched the delivery dates indicated by Pharmacy Technician 3 during the above 10/28/25, 10:48 a.m. interview.An interview was conducted with LPN 2 on 10/28/25 at 11:00 a.m. She indicated she probably didn't see the medication in the medication cart on 10/16/25, but she went into Resident B's room first to ask him if he wanted to take his medications, and he normally refused, so I don't even prep [prepare] them beforehand. She couldn't say for sure if she informed NP (Nurse Practitioner) 4, Resident B's psychiatric NP, about him not receiving the Uzedy on 10/16/25, but NP 4 was aware he regularly refused his medications. Resident B had physically aggressive behaviors.An interview was conducted with the DON on 10/28/25 at 11:09 a.m. He indicated the Uzedy was available for administration on 10/16/25, so it should have been administered. If he refused it, LPN 2 should have documented refusal, instead of unavailable. A lot of Resident B's behaviors were verbal aggression and refusal of care and medications. When he was sent to the inpatient psychiatric hospital on 9/3/25, he had thrown feces on staff, but that wasn't a regular thing. He could also be physically combative with staff. Typically, when he administered medications, he prepared the medications first, then took them into the residents' room for administration. If the resident refused, he destroyed the medication.An interview was conducted with NP 4 on 10/28/25 at 2:07 p.m. She indicated she began providing services at the facility in August, 2025. Resident B had behaviors and was irritable, aggressive, and refused care. He stopped taking his medication. She saw him just not wanting to be bothered, and would face the wall, while mumbling to himself. The facility did not inform her that he didn't receive his Uzedy injection this month, as ordered. She stated, I would have loved for them to tell me. He hadn't been taking his oral medications either. That was one reason injectable medications were used. It's the only way we can stabilize him. He should receive the Uzedy. She didn't know why he didn't get it. She was going to follow up later in the week to make sure he received the Uzedy injection, because he would not take the oral medication, Depakote Sprinkles, currently prescribed to him