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	03/11/2026

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 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 timely have the interdisciplinary team (IDT) determine and document that self-administration of medications and treatments were clinically appropriate for 2 of 16 residents reviewed. (Resident B and Resident N)Findings include: 1.The clinical record for Resident B was reviewed on 3/10/26 at 11:30 a.m. The resident's diagnosis included, but was not limited to, personality disorder (behavior that deviates markedly from cultural expectations). A Quarterly Minimum Data Set (MDS) assessment, dated 12/16/25, indicated Resident B was cognitively intact. A current physician's order, with a start date of 1/21/21, indicated Resident B was prescribed 81 milligrams of aspirin daily.A current physician's order, with a start date of 11/16/23, indicated Resident B was prescribed 2 capsules of 100 milligrams o docusate sodium twice a day. A current physician's order, with a start date of 10/18/24, indicated Resident B was prescribed 1000 milligrams of acetaminophen three times a day.A current physician's order, with a start date of 3/28/25, indicated Resident B was prescribed vitamin b-12 daily before breakfast.A current physician's order, with a start date of 2/23/26, indicated Resident B was prescribed 800 milligrams of gabapentin three times a day.A current physician's order, with a start date of 2/24/26, indicated Resident B was prescribed 0.3/1.5 milligrams prempro daily.A current physician's order, with a start date of 2/28/26, indicated Resident B was prescribed 25 milligrams of hydroxyzine daily.A current physician's order, with a start date of 3/10/26, indicated Resident B was prescribed 2 tablets of 10 milligrams of lisinopril daily. An observation and interview, on 3/11/26 at 10:37 a.m., of Resident B's room, the resident was in bed with a bedside table next to her. There was a cup observed with multiple medications sitting on the bedside table. No staff were present in the resident's room. Resident B indicated the cup of medications were her morning medications. She had heartburn and she was going to take her medications later. At 10:40 a.m., the resident indicated she was able to take her own medications. While in the resident's room Licensed Practical Nurse (LPN) 3 had entered the resident's room to administer another medication to the resident. The LPN indicated the medication she brought in was the resident's lisinopril. The resident spoke with the LPN and LPN 3 placed the second medication cup with the pill inside the cup on the resident's bedside table next to the other medication cup with pills inside of it and left the resident's room. Resident B's clinical record lacked a current self-administration assessment or a physician's order for the resident to self-administer her medications.2. The clinical record for Resident N was reviewed on 3/10/26 at 2:30 p.m. The resident's diagnosis included, but was not limited to Schizophrenia (a chronic severe mental disorder characterized by disruptions in thought processes and perceptions). An admission MDS Assessment, dated 1/19/26, indicated Resident N was cognitively intact. A current physician's order, with a start date of 1/7/26, indicated Resident N was prescribed 1 tablet of tums every 6 hours as needed and 10 milligrams of Buspar three times a day. An observation was made of Resident N on 3/10/26 at 2:35 p.m. The resident was observed sitting on her bed. There was a bedside table sitting by her and the bed with a medication cup observed to have 1 (greenish) pill and 1 (pinkish) pill in the cup. The resident indicated the pills were tums. Resident N's clinical record lacked a documented self-administration assessment or a physician's order to self administer her medicaitons. An interview was conducted with the Nurse Consultant on 3/11/26 at 9:15 a.m. She indicated she was (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to find current self-administration assessments for Resident B or Resident N. A self-medication assessment policy was provided by the Nurse Consultant on 3/11/26 at 9:17 a.m. The policy indicated .Self-administration medications will be encouraged if it is desired by the resident, safe for the resident and other residents of the facility, ordered by the attending physician, and approved by the Interdisciplinary Team. Procedure: 1. Each resident is offered the opportunity to self-administer his or her medications during the routine assessment by the facility interdisciplinary team .5. A physician order is obtained to self-administer Medication if the above storage and self assessment has been approved for the resident by the interdisciplinary team. The order is recorded on the MSR .11. Update the residents care plan quarterly or as indicated by the change in medication scheduling, dose or a change in resident's condition with a reassessment of the resident's knowledge and ability to self-administer medications. 410 IAC (Indiana Administrative Code) 16.3.1-11

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident for 1 of 5 residents reviewed for abuse (Resident E).Findings include: The clinical record for Resident E was reviewed on 3/10/26 at 11:15 a.m. The resident's diagnoses included, but were not limited to, dementia (mental decline) and depression. A Quarterly Minimum Data Set (MDS) assessment, dated 1/8/26, indicated the resident had severely impaired cognition. The resident was able to make himself understood, understood others, and had no behaviors noted during the assessment period. A care plan, initiated on 1/19/26, indicated Resident E had impaired cognitive function or impaired thought process. The goals included, but were not limited to, the resident would remain oriented to person, place situation and time. Resident E's clinical record included a follow-up progress note, dated 2/26/26 at 12:27 p.m., that indicated the resident was being seen for a medication follow-up. Resident E had a resident-to-resident encounter during the past weekend. Resident E reported he was not bothered about the encounter, but staff reported that he appeared anxious since the incident. On 3/10/26 at 11:24 a.m., an interview was conducted with Resident E. The resident indicated there was a resident who had been mean to him and was messing with him. The other resident had hit him and the other resident sat behind Resident E in the dining room. Resident E tried to stay away from the other resident. On 3/10/26 at 11:55 a.m., a continuous observation was conducted in the second floor dining room. At 12:12 p.m., Resident D entered the dining room and went to sit at a table behind Resident E. On 3/11/26 at 10:58 a.m., the Nurse Consultant (NC) provided a copy of the investigation file for the incident between Resident D and Resident E. The investigation file included an incident report, dated 2/24/26 at 4:58 p.m., that indicated Resident D had made contact with the head of Resident E. Resident D used an open hand and there were no injuries noted to either resident. During an interview on 3/11/26 at 12:10 p.m., Licensed Practical Nurse (LPN) 12 indicated she had been the one to separate Resident D and Resident E on 2/24/26. The LPN had not witnessed the incident but had been informed by another resident who had seen it happen. LPN 12 had spoken with Resident D at the time of the incident. Resident D had not denied hitting Resident E. Resident D indicated that Resident E would not be quiet. On 3/10/26 at 11:27 a.m., the NC provided the Abuse Prevention Program policy, dated 10/22/22. The policy indicated .it is the policy of this facility to prevent resident abuse .For the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain .Abuse: the willful infliction of injury .intimidation or punishment with resulting physical harm, pain, mental anguish .to attain or maintain physical, mental, and psychosocial well-being .Physical Abuse: Hitting, slapping .etc . 410 IAC (Indiana Administrative Code) 16.31-27(a)(1)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to document thorough investigations for allegations of abuse for 1 of 5 residents investigated for abuse (Resident F).Finding include: The clinical record for Resident F was reviewed on 3/10/26 at 1:10 p.m. The resident's diagnosis included, but was not limited to, Down Syndrome (genetic condition resulting in distinct physical features, developmental delays, and mild-to-moderate intellectual disabilities). On 3/11/26 at 10:58 a.m., the Nurse Consultant (NC) provided a copy of the allegation of abuse investigation for Resident F for review. The investigation file contained an Incident Report, dated 12/27/25, that indicated Resident F had witnessed a verbal disagreement between Qualified Medication Aide (QMA) 10 and Certified Nursing Assistant (CNA) 11. The immediate action taken was to suspend QMA 10 and CNA 11 pending outcome of the investigation. The investigation file did not contain statements from QMA 10 or CNA 11 about the verbal disagreement. On 3/11/26 at 12:58 p.m., the NC provided a written statement from QMA 10, dated 12/27/25, that indicated QMA 10 and CNA 11 had gotten into an argument at the nurses' station about CNA 11 not assisting with passing out trays in the dining room. CNA 11 had made accusation against QMA 10 and accused QMA 10 of talking about CNA 11 with the residents. Resident F had been in her room at the time the argument began but had come into the hallway and witnessed the argument between QMA 10 and CNA 11. During an interview on 3/11/26 at 1:06 p.m., the Executive Director (ED) indicated there was not a written statement from CNA 11. The ED and the weekend supervisor had interviewed CNA 11 together but had not written the interview down. CNA 11 had rescinded the accusation against QMA 10. During an interview on 3/11/26 at 1:19 p.m., CNA 11 indicated she had written a statement about the incident on 12/27/25, and given it to the ED. The argument between QMA 10 and CNA 11 had started over CNA 11 refusing to serve trays with regular consistency food to residents who were on mechanically altered diets. During an interview on 3/11/26 at 1:27 p.m., the ED indicated CNA 11 had not provided a written statement. The ED indicated she would not recognize CNA 11 in person. The statement from CNA 11 had been taken over the phone. On 3/10/26 at 11:27 a.m., the NC provided the Abuse Prevention Program policy, dated 10/22/2022, that read . The Charge Nurse must complete an incident report and obtain a written, signed and dated statement from the person reporting the incident. A completed copy of the incident report and written statements from the witnesses, if any, will be provided to the Administrator or individual in charge of the facility within twenty-four (24) hours of the occurrence of such incident . 410 IAC (Indiana Administrative Code) 16.3.1-28(d)

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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 a urinary catheter was available for resident use for 1 of 1 resident reviewed for urinary catheters. (Resident G)Findings include: The clinical record for Resident G was reviewed on 3/10/26 at 11:30 a.m. The diagnoses included, but were not limited to, paraplegia (paralysis of lower body) and neuromuscular dysfunction of bladder (loss of bladder control). An admission Minimum Data Set (MDS Assessment, dated 2/18/26, indicated Resident G was cognitively intact. A care plan, dated 2/7/26, indicated the resident had the potential for infection due to the need for intermittent self-catheterization (resident will insert a tube to empty his bladder) related to neurogenic bladder. A physician's visit note, dated 2/13/26, indicated Resident G wanted to be seen due to urgent request regarding catheter supplies.patient reports he is running low on straight catheters and requires an order to prevent running out. He verbalizes concern that without appropriate supply he would be forced to reuse catheters, increasing risk of infection. Given his history of recurrent UTI [Urinary Tract Infections] with sepsis, we discussed the importance of sterile, single-use technique to reduce UTI risk.Nursing notified and order placed.16F [French] straight catheters for intermittent catheterization. The resident reports ongoing concerns regarding the management of his neurogenic bladder, specifically noting that he has not been consistently receiving straight catheterizations as previously instructed. Patient expresses frustration and anxiety regarding interruptions in his catheterization schedule, emphasizing concern about potential bladder overdistention and associated complications. Patient reports understanding that intermittent catheterization is recommended every 4-6 hours during the day to maintain bladder health and prevent complications such as urinary retention or infection. He notes difficulty adhering to this schedule due to limitations in catheter supply. Nursing staff report that the patient was provided with a box of catheters and that if the supply is exhausted prematurely, it may indicate overuse or improper scheduling. Patient demonstrates awareness of the plan to monitor bladder volumes, with target volumes of 400-500 mL [milliliters] to prevent overdistention and potential renal complications.Patient [Resident G] verbalizes clear understanding of the intermittent catheterization plan and expresses willingness to adhere to the prescribed schedule, pending adequate catheter supply. He is motivated to participate in self-care and demonstrates appropriate insight into the importance of bladder management to prevent complications. A physician's order, dated 2/13/26, indicated staff were to provide Resident G 16 French straight urinary catheters (single-use, flexible tube with a straight tip, primarily used for intermittent catheterization to drain the bladder) for self-removal of urine from his bladder. An interview was conducted with Resident G on 3/10/26 at 11:33 a.m. He indicated he had been asking since 9:00 a.m. that morning for a supply of urinary catheters. He had just received 4 urinary catheters from the nursing staff for the day at approximately 11:15 a.m. He had not emptied his bladder since last night. It was difficult with long delays to receive the urinary catheter supply. The resident was told by the medical provider he would receive at least 5 urinary catheters for the day. He was unsure why he couldn't have the entire box but was agreeable with 5 catheters. The staff are only giving him 4 urinary catheters, which was not enough. Today, he just received 4 urinary catheters to use for the day. He was supposed to empty every 4 to 6 hours a day depending on how much he drinks. I know when I have to empty my bladder. It's ridiculous. During the evening and night shifts, he will ask the staff when he runs out of supply for more, but they report they don't know where the supply was located or the supply was gone. He needs at least one for the evening and one for the nighttime. He has had to reuse his urinary catheters at night due to not receiving enough supply. The resident's physician had educated the resident about not reusing catheters. He indicated he was aware of the risk of infection, but what do you do when you have to empty your bladder with no supplies? The resident at that time opened his drawer to his night table, and there were three packaged new urinary (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheters observed. Resident G indicated that was all the supply he would receive for the day.An interview was conducted with the Nurse Practitioner 2 on 3/10/26 at 3:00 p.m. She indicated she had spoken to nursing regarding the resident's concerns with receiving supply of urinary catheters to empty his bladder. He should be receiving enough urinary catheters to have the ability to empty his bladder at least every 4 to 6 hours and as needed. The frequency does depend on how much he drinks, so he could have to empty his bladder more frequently. An interview was conducted with Qualified Medication Aide (QMA) 1 on 3/10/26 at 3:14 p.m. She indicated she ordered the urinary catheters for Resident G. She was at one time giving him several urinary catheters, but he was going through them quickly. She had given him 20 urinary catheters almost an entire box over a weekend. He had gone through all of them before the weekend was up. She was unaware Resident G was emptying his bladder every 4 to 6 hours. She thought he was supposed to be emptying his bladder every 8 hours. Nursing staff had not updated her Resident G's order had changed with the increased frequency of emptying his bladder. The urinary catheter supply was stored in the medical supply storage room. At that time, an observation was made of the medical supply room. There was one box that contained nineteen 16F urinary catheters for Resident G. QMA 1 indicated she had ordered another supply for Resident G and should be there that day. The evening and night staff had access to the medical supply room. An observation was made of Resident G's room on 3/12/26 at 3:14 a.m. Resident G opened his bedside table and there were two new packaged urinary catheters observed.An interview was conducted with the Nurse Consultant on 3/10/26 at 3:41 p.m. She indicated Resident G will receive more than four urinary catheters going forward. The facility does not have a policy for self-catheterization that addresses the availability of supplies.410 IAC (Indiana Administrative Code) 16.3.1-41(a)(2)

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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. Based on observation, interview, and record review, the facility failed to ensure new behaviors were documented in the clinical record and to ensure staff were monitoring and tracking behaviors for 1 of 5 residents reviewed for abuse and 1 of 5 residents reviewed for call light response (Resident B and Resident D).Findings include:1. The clinical record for Resident D was reviewed on 3/10/26 at 11:20 a.m. The resident's diagnoses included, but were not limited to, dementia (mental decline) and bipolar disorder (a chronic mental health condition causing extreme shifts in mood, energy, and activity levels). A physician's order, dated 4/24/25, indicated Resident D's behavior was to be monitored each shift for delusions/hallucinations, tearfulness, crying, verbal expressions of sadness, anger, yelling, cursing, insomnia, anxiety, skin picking, and physical aggression. A Quarterly MDS Assessment, dated 1/9/26, indicated the resident had moderately impaired cognition and had not displayed behaviors during the assessment period. A care plan, revised on 1/21/26, indicated Resident D had displayed behavioral symptoms related to delusions, hallucinations, tearfulness, crying, verbal expressions of sadness, anger, yelling, cursing, insomnia, anxiety, skin picking, and physical aggression. The goal was for him to comply with staff redirection and behave in a safe and respectful manner. The interventions included, but were not limited to, conduct an evaluation of my behavioral symptoms to determine what strengths or abilities and needs are communicated via the behavior, intervene when inappropriate behavior was observed. A follow-up progress noted, dated 2/26/26 at 10:51 a.m., indicated Resident D had a recent resident to resident bodily contact incident. The February 2026 Medication Administration Record indicated Resident D had not displayed any behaviors during the month. Resident D's clinical record did not contain a behavior note addressing his behavior of hitting another resident. On 3/10/26 at 11:20 a.m., the Nurse Consultant (NC) provided the investigation file for the resident-to-resident incident that Resident D had been involved in on 2/24/26. The file contained an incident report that indicated Resident D had made contact with the head of another resident, using an open hand. There were no injuries to either resident. During an interview on 3/10/26 at 3:48 p.m., the Social Services Director (SSD) indicated Resident D was not normally aggressive to other residents. When a resident had new behaviors, the nurse should have documented the behavior in the clinical record using a behavior progress note and the new behavior would be reviewed in the morning meeting. The Interdisciplinary (IDT) Team had discussed Resident D striking another resident after it occurred. The IDT team had been unable to come up with a root cause for the behavior. There had been no new care plan started, and no new interventions added to Resident D's behavior care plan since the incident on 2/24/26. During an interview on 3/11/26 at 12:10 p.m., Licensed Practical Nurse (LPN) 12 indicated she had been the one to separate Resident D and the other resident on 2/24/26. LPN 12 had not witnessed the (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident but had been informed by another resident who had seen it happen. LPN 12 had spoken with Resident D at the time of the incident. Resident D had not denied hitting the other resident. Resident D had indicated that the other resident would not be quiet. LPN 12 had assumed that was why Resident D had hit the other resident. The intervention was for there to be a Certified Nursing Assistant (CNA) in the dining room at all times when there are residents in the dining room. 2. The clinical record for Resident B was reviewed on 3/10/26 at 11:30 a.m. The resident's diagnosis included, but was not limited to, personality disorder (behavior that deviates markedly from cultural expectations). A Quarterly Minimum Data Set (MDS) assessment, dated 12/16/25, indicated Resident B was cognitively intact. A physician's order, dated 8/12/25, indicated the staff were to monitor Resident B's behaviors. The following behaviors were to be monitored and tracked, calling emergency services, false accusations/beliefs, anxiety, tearfulness, insomnia, refusal of care, verbal aggression, throwing objects, OCD (obsessive-compulsive disorder) behaviors, crying, verbal expressions of sadness, racial slurs, self-isolation, anger, yelling, and cursing. The staff were to implement the following interventions to address the resident's behaviors: attempt redirection; snack; fluid offered; Activity for diversion; toileting; change of environment; pain assessment; offer nap/rest period; and provide comfort. The March 2026 Medication/Treatment Record (MAR/TAR) indicated Resident B had not exhibited any behaviors as of 3/11/26. During an interview with Resident B on 3/11/26 at 10:37 a.m., License Practical Nurse (LPN) 3 arrived in the resident's room to administer a medication. The resident was curt in tone with LPN 3 about the delivery of the type of medication she had brought in the room. The LPN responded politely and left the room. An interview was conducted with LPN 3 on 3/11/26 at 11:33 a.m. She indicated she had returned to Resident B's room a little while ago. As soon as she entered the room, the resident started screaming and yelling at her about the medication she had delivered earlier that morning. LPN 3 was unsure why the resident was upset. Resident B's clinical record lacked documented behaviors for the behavior observed on 3/11/26 with LPN 3. The resident's clinical record lacked any implemented interventions provided for Resident B related to the behavior exhibited with LPN 3 at that time. During an interview on 3/12/26 at 12:23 p.m., the NC indicated the nurses should document behaviors on the Medication Administration Record (MAR) which triggered the nurse to enter a progress note. On 3/10/26 at 2:16 p.m., the NC provided the Guidelines for Behavior Management Meetings Psychotropic Medication policy, dated 8/18/23, that read .These meetings are held monthly or more often as needed. The purpose is to review residents who have behaviors and who are being monitored for these behaviors. Further, to discuss and review residents who have newly developed behaviors to ensure that all appropriate interventions are in place to manage the behaviors . Nursing .Monitors for presence of target behaviors on a daily basis and documenting same . 410 IAC (Indiana Administrative Code) 16.3.1-37