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	06/03/2026

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation and record review, the facility failed to ensure a resident's right to privacy and dignity during 1 of 1 care observations in which 1 of 3 residents reviewed for care and services did not have the door or privacy curtain closed in a manner to provide privacy and dignity during the process of transferring the resident from the wheelchair into their bed. (Resident C) Findings include:During an interview with a family member of Resident C on 6-2-26 at 4:15 p.m., Resident C was sitting in her wheelchair and indicated she wanted to lay down. During an observation on 6/2/26 at 4:15 p.m., CNA 3 and CNA 4 entered Resident C's room and transferred the resident from the wheelchair to the bed. The resident's privacy curtain was not pulled closed and the resident's door was not shut during this observation. Resident C's transfer was visible from the hallway of the facility. A review of Resident C's clinical record on 6-3-26 at 1:50 p.m., indicated her diagnoses included, but were not limited to, unspecified dementia and a cerebral infarction (stroke) causing paralysis to the left side of her body. Her most recent Minimum Data Set analysis, dated 5-8-26, indicated she was severely cognitively impaired.On 6-3-26 at 3:19 p.m., the Executive Director provided an undated copy of a policy entitled, Your Rights and Protections as a Nursing Home Resident. This policy indicated, [You have the] right to be treated with dignity and respect .get proper privacy .The Indiana Department of Health's Nurse Aide Curriculum (revised 3-21-14) indicated, avoid unnecessary exposure.410 IAC (Indiana Administrative Code) 3.1-3(t)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the use of a gait belt (device used to enhance safety during movement while assisting another person) during the transfer of 1 of 3 residents reviewed for care and services during 1 of 1 care observations. (Resident C) Findings include: During an interview with CNA 3 on 6-2-26 at 4:05 p.m., she indicated she was aware Resident C was a big fall risk, and had a history of falls. During an interview with a family member of Resident C on 6-2-26 at 4:15 p.m., Resident C was sitting in her wheelchair and indicated she wanted to lay down. During an observation on 6-2-26 at 4:15 p.m., CNA 3 and CNA 4 entered Resident C's room they were observed to don gloves, prior to beginning the care to transfer the resident from the wheelchair to her bed. CNA 3 and CNA 4 were observed to explain each step of the transfer from the wheelchair to the bed with Resident C. The staff members were observed to instruct Resident C to stand up with assistance of both CNA's, while placing their arms under her arms, towards her back. Resident C was observed to stand and pivot one to two steps to sit down onto the mattress of her bed. The staff members were observed to assist the resident by placing her legs onto the bed and position her onto her back. CNA 3 and 4 did not utilize a gait belt during the transfer. During an interview with CNA 3 on 6-2-26 at 4:15 p.m., she indicated normally she would use a gait belt with Resident C's transfers, but unable to find a gait belt to use during the transfer. A review of Resident C's clinical record on 6-3-26 at 1:50 p.m., indicated her diagnoses included, but were not limited to, unspecified dementia, a history of repeated falls and a cerebral infarction (stroke) causing paralysis to the left side of her body. Her most recent Minimum Data Set analysis, dated 5-8-26, indicated she was severely cognitively impaired, did not walk or ambulate, had a history of falls and fractures prior to admission on [DATE], and had sustained two or more falls without injury since her admission.On 6-3-26 at 11:39 a.m., the Executive Director provided an undated copy of a procedure entitled, Transfer Belts/Gait Belts. This procedure indicated, It is the intent of the facility to promote safety in transferring and ambulating residents, a gait belt [sic] .A gait belt was used as indicated for safety by the person qualified to transfer the Resident .to provide stability and balance during movement.410 IAC (Indiana Administrative Code) 3.1-45(a)(2)

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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 prevent a urinary catheter bag or its tubing from coming in contact with the floor during 1 of 1 care observations for 1 of 3 residents reviewed for care and services. (Resident C) Findings include:During an observation for Resident C on 6-2-26 at 4:15 p.m., CNA 3 and CNA 4, were observed to assist the resident to transfer from her wheelchair and into her bed. The staff were observed to have the bed at a level of comfort and ease for her to move from the wheelchair to her bed. The staff were observed to place her urinary catheter bag onto the right side of the bed frame and the bag and tubing were not in contact with the floor. Upon completion of the care, the staff were observed to lower Resident C's bed into its lowest position. The urinary catheter bag and its tubing were in contact with the floor. The staff were observed to to clean up the area and exit the room. During an interview with CNA 4 on 6-2-26 at 4:20 p.m., indicated Resident C's catheter bag and tubing should not be touching the floor. CNA 4 found a wash basin under Resident C's bed and took the catheter bag and tubing from the floor and placed them in a wash basin. During an interview with the Corporate Nurse on 6-3-26 at 11:36 a.m., she indicated the facility did not have any policies or procedures that specifically address not allowing the urinary catheter bags or tubing to not touch the floor. She indicated staff education addressed the urinary collection bag and tubing should not come in contact with the floor.The clinical record for Resident C was reviewed on 6-3-26 at 1:50 p.m. Her diagnoses included but were not limited to unspecified dementia, neuromuscular dysfunction of the bladder (disruption that impairs the ability to store and empty urine) and urinary retention. The admission Minimum Data Set assessment for Resident C, dated 5-8-26, indicated she had an indwelling catheter.On 6-3-26 at 11:39 a.m., the Executive Director provided a copy of an undated policy entitled, Catheters. This policy indicated, It is the policy of the facility to ensure .appropriate treatment and services to prevent urinary tract infections .Insertion, ongoing care and catheter .protocols that adhere to professional standards of practice and facility policy and procedure with adherence to infection prevention and control techniques. 410 IAC (Indiana Administrative Code) 3.1-41(a)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to have complete and accurate documentation for a resident's follow- up physician appointments for 1 of 3 residents reviewed for physician appointments. (Resident C). Finding include:The clinical record of Resident B was reviewed on 6-2-26 at 2:42 p.m. Her diagnoses included, but were not limited to unspecified dementia (mental decline), low back pain, unspecified disease of the spinal cord, spinal stenosis of the lumbar region with neurogenic claudication (narrowing of the spine causing pain in the legs and buttocks) and a history of falls. The Minimum Data Set assessment for Resident C, dated 3-26-26, indicated she was cognitively impaired and was unable to walk or ambulate independently, required the use of a wheelchair for mobility. A review of her clinical record indicated she was sent out to the hospital on [DATE], related to an altered mental status. Upon her discharge from the hospital, she returned to the facility. Her hospital discharge medical orders, received on 10-29-25, included for the facility to schedule a follow-up appointment with a neurologist. A review of the clinical record failed to identify if any appointments had been scheduled for her to see a neurologist. In an interview with the Corporate Nurse on 6-3-26 at 11:45 a.m., she indicated she did locate information of appointments scheduled in the facility's electronic calendar in which Resident B was identified to have appointments scheduled for her to be transported by the facility to neurology appointments on 11-14-25, 1-13-26 and 2-14-26. The Corporate Nurse clarified she was unable to locate any documentation on/around those dates to support if Resident B had attended any of those appointments or any associated documentation from the specialist. The Corporate Nurse was unable to locate any information to suggest any further attempts had been made to reschedule the previously requested referral made for Resident B with a neurologist.On 6-3-26 at 3:00 p.m., the Executive Director provided a copy of an undated policy entitled, Guidelines for Electronic Health Record Documentation. This policy indicated its purpose as, A medical record is maintained for each resident to provide a permanent record of the care provided .The following medical records are being maintained .physician orders .progress notes .miscellaneous documents .Documentation guidelines include but may not be limited to: changes in condition .behaviors .documentation required by each discipline--timely and accurate.This Federal tag relates to Intake 3026020.410 IAC (Indiana Administrative Code) 3.1-50(a)(1)410 IAC (Indiana Administrative Code) 3.1-50(a)(2)