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	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Castleton Skilled Nursing Facility, The	8400 Clearvista Pl Indianapolis, IN 46256

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure outdated items were discarded from the refrigerator timely, items were not open to air in the refrigerator, and the kitchen and kitchen equipment were clean with the potential to affect 50 of 51 residents residing at the facility.Findings include: On 12/9/25 at 9:45 a.m., the facility kitchen was observed with the Dietary Manager (DM). The walk-in refrigerator contained a silver pan of gelatin, dated 11/30/25, and a package of sliced cheese that was not sealed. The DM indicated the gelatin should be discarded and the cheese should have been wrapped completely and would be discarded. The kitchen floor had a film and did not appear to be clean. On 12/11/25 at 10:27 a.m., the facility kitchen was observed to have a dirty film and did not appear to have been mopped. On 12/11/25 at 12:35 p.m., the second-floor kitchenette was observed. The inside of the double-door refrigerator had dried food substances at the sides of the floor and a piece of fuzz stuck to the floor on the bottom of the interior refrigerator door. The bottom shelf of the steam table had a white film and dark, rust looking spots were present on the shelf. The prep table at the back of the kitchenette had a tray of white souffle cups on the bottom shelf. One of the souffle cups had dried on food stuck to the inside of the cup. During an interview on 12/11/25 at 12:50 p.m., Dietary [NAME] 23 indicated the white souffle cup needed to be washed again. On 12/11/25 at 2:15 p.m., the facility kitchen and second floor kitchenette were observed with the DM. The DM indicated the kitchen floor needed to be mopped and should be mopped daily. The second-floor kitchenette refrigerator floor needed to be cleaned. The DM was unsure what caused the white film on the bottom shelf of the steam table. He indicated the steam table was older and needed to be cleaned. On 12/11/25 at 2:30 p.m., the DM provided the Food Storage policy, last reviewed 8/12/23, that read .Food storage areas will be clean, dry and maintained at temperatures as required to ensure food safety .5. All open products [as able] will be sealed [rolled closed, wrapped closed, with lid closed, etc] to ensure quality and prevent contamination against pests or rodents . 7. Good that have been opened with no date, left on the floor, or not properly sealed will be discarded. 8. All outdated goods will [sic] discarded the day after expiration . 3.1-21(l)(3)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to timely discontinue an anti-psychotic medication as recommended by pharmacy and medial provider for 1 of 6 residents reviewed for unnecessary medications. (Resident 7) Findings include: The clinical record for Resident 7 was reviewed on 12/9/25 at 3:00 p.m. The resident's diagnoses included, but were not limited to, dementia. A physician order, dated 9/15/25, indicated Resident 7 was to receive 0.25 milligrams of risperidone at night for agitation. A November 2025 pharmacy recommendation for Resident 7 indicated the medical provider needed to provide justification for the usage of the 0.25 milligrams of risperidone at bedtime for agitation. The medical provider responded with discontinuation of the 0.25 milligrams of risperidone at bedtime for Resident 7 as of 12/4/25. The staff was to monitor the resident for worsening symptoms. A medical provider note, dated 12/4/25, indicated the pharmacy had reviewed Resident 7's medications. The recommendation indicated that the resident does not have appropriate diagnosis to support the use of risperidone 0.25 mg (milligrams) at hs [night]. It is appropriate to discontinue medication at this time. A December 2025 Medication Administration Record (MAR) indicated the following days Resident 7 had received the 0.25 milligrams of risperidone nightly after the medical provider indicated to discontinue the risperidone medication: 12/4/25, 12/5/25, 12/6/25, 12/7/25, 12/8/25, 12/9/25, and 12/10/25. An interview was conducted with the Nurse Consultant on 12/11/25 at 11:50 a.m. She indicated Resident 7's 0.25 milligrams of risperidone she received nightly should have been stopped. It was missed.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a transfer form was sent with a resident who was transferred to an acute care hospital for 1 of 2 residents reviewed for hospitalization (Resident 2)Findings include: The clinical record for Resident 2 was reviewed on 12/10/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and history of falling. An interview was conducted with Resident 2's Representative on 12/10/25 at 11:37 a.m. She indicated Resident 2 had been hospitalized for low blood sugar at the beginning of October. Resident 2's medical record did not include a transfer form for the resident being discharged to the hospital. Hospital records for Resident 2 were provided by the Nurse Consultant on 12/16/25 at 1:32 p.m. It indicated Resident 2 was brought in by Emergency Medical Services (EMS) and admitted to the hospital on [DATE]. The chief complaint was altered mental status. An interview was conducted with the Director of Nursing on 12/15/25 at 3:17 p.m. He indicated Resident 2 was discharged to the hospital by EMS on 9/25/25. He was unable to locate discharge transfer form staff had completed for that resident. A transfer and discharge policy was provided by the Nurse Consultant on 12/12/25 at 10:03 a.m. It indicated, .Emergency Transfer:.7. Complete the Resident Transfer form make 2 copies of any portion of the health record necessary for care of resident. (E.g. Physician orders, History and Physical, chest x-ray, immunization information, any pertinent lab work etc.) 8. Send original of transfer form and portions of health record that was copied with the resident, attach the second copy of the portions of the health record to the facility copy of the transfer form. Give the third copy of the transfer form to the DON.

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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 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 a care plan accurately reflected resident wishes regarding discharge and to ensure care plan meetings were held timely for 2 of 3 residents reviewed for discharge care plans, 1 of 1 resident reviewed for notification of change, and 1 of 3 residents reviewed for care plans (Resident 4, Resident 37, Resident 36, and Resident 20)1. The clinical record for Resident 4 was reviewed 12/12/2025 at 1:30 p.m. The medical diagnoses included, but were not limited to, diabetes and polyneuropathy. A Quarterly Minimum Data Set Assessment, dated 9/4/2025, indicated Resident 4 was cognitively intact, had no active discharge planning, and did not want to speak to someone about returning to the community. A discharge care plan, dated 8/31/2023 and revised on 11/8/2025, indicated Resident 4 wanted to discharge home. The interventions included, but were not limited to, for staff to offer support and encouragement as needed. A progress note, dated 6/19/2025, indicated Resident 4 wished to stay in the facility and not discharge to the community. 2. The clinical record for Resident 37 was reviewed on 12/11/2025 at 3:15 p.m. The medical diagnoses included, but were not limited to, malnutrition and hypertension. A Quarterly Minimum Data Set Assessment, dated 10/9/2025, indicated Resident 37 was not cognitively intact, had no active discharge planning, and did not want to speak to someone about returning to the community. A discharge care plan, dated 2/25/2025 and revised 10/2/2025, indicated Resident 37 would stay in the facility long term. The interventions, indicated social services to schedule discharge needs as needed. During an interview with Family Member 11, on 12/10/2025 at 11:56 a.m., she indicated she wanted Resident 37 to discharge to an assisted living. She has been working with someone about Resident 37's insurance and discharge, but they stopped responding. A progress note, dated 6/26/2025, indicated Resident 37's family would like to know if he qualified for assisted living and would like to reapproach after Medicaid waiver was approved. A census log for Resident 37 indicated Medicaid as the payor source starting 6/1/2025. During an interview, on 12/12/2025 at 3:05 PM, the Administration indicated it was the responsibility of the Social Service Designee to revise and update the discharge planning care plans. 3. The clinical record for Resident 36 was reviewed on 12/9/25 at 2:20 p.m. The resident's diagnosis included, but were not limited to, dementia and dysphagia (inability to swallow). A Quarterly Minimum Data (MDS) Assessment, completed 11/13/25, indicated she was severely cognitively impaired. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/9/25 at 2:20 p.m., Family Member (FM) 10 indicated she had not attended a care plan meeting for Resident 36 since July 2025. On 12/10/25 at 2:50 p.m., the Nurse Consultant (NC) provided care plan meeting notes for Resident 36. The last care plan meeting for Resident 36 was held 7/3/25. 4. The clinical record for Resident 20 was reviewed on 12/9/25 at 2:44 p.m. The resident's diagnosis included, but was not limited to, hypertension and diabetes. A Quarterly MDS Assessment, completed 9/24/25, indicated he was cognitively intact. During an interview on 12/9/25 at 2:44 p.m., Resident 20 indicated he did not recall ever having a care plan meeting. On 12/10/25 at 2:50 p.m., the NC provided the care plan meeting notes for Resident 20. The last care plan was held on 6/24/25. During an interview on 12/10/25 at 2:50 p.m., the NC indicated families should be invited to care plan meetings. Care plan meetings are held quarterly. On 12/12/25 at 1:30 p.m., the Director of Nursing provided the Baseline Care Plan Assessment/ Comprehensive Care Plans Policy, last revised 3/23/21, that read As the resident remains in the Nursing Home, additional changes will be made to the comprehensive care plan based on the assessed need of the resident . 5. The facility Social Services Director or designee will notify the resident's responsible party either by letter or a phone call to inform them of the scheduled Care Plan Conference to include the date and time . 9. The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum . 3.1-45(b)(1)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and record review, the facility failed to ensure the optometry plan of care was implemented for a resident with glaucoma for 1 of 1 resident reviewed for vision services (Resident 17).Finding include: The clinical record for Resident 17 was reviewed on 12/9/25 at 11:45 a.m. The resident's diagnosis included, but was not limited to, glaucoma.An Eye Care Chart Note, dated 4/11/25, indicated Resident 17 had blurred vision in the right and left eyes. The assessment and plan was to treat her open-angle glaucoma in both eyes with brimonidine 0.1% dorzolamide 2% (medication to treat high eye pressure) eye drops 1 drop into each eye twice daily and latanoprost 0.0005% eye drop (medication to treat open-angle glaucoma) one drop in both eyes at bedtime.A physician's order, dated 4/26/25, indicated she was to receive brimonidine tartrate ophthalmic solution 0.2 % 1 drop into both eyes two times a day for glaucoma.The clinical record did not contain an order for latanoprost eye drops. A Quarterly Minimum Data Set (MDS) Assessment, completed 11/28/25, indicated Resident 17 had moderately impaired cognition and severely impaired vision. During an interview on 12/09/25 at 11:45 a.m., Resident 17 indicated she had not received eye drops in a very long time. She had glaucoma and did not know why she was not receiving eye drops. On 12/10/25 at 9:45 a.m., Resident 17 was observed receiving her morning medications. Resident 17 did not receive eye drops from the nurse administering the medications. Resident 17 indicated she had not received eye drops in a long time. The November and December Medication Administration Record (MAR) indicated that the brimonidine tartrate ophthalmic solution 0.2 % had been given daily. During an interview on 12/11/25 at 11:05 a.m., Pharmacy Technician 21 indicated Resident 17 had not had a refill of the brimonidine tartrate ophthalmic solution 0.2 % sent to the facility since April 2025. During an interview on 12/11/25 at 11:45 a.m., the Director of Nursing indicated the latanoprost eye drops for Resident 17 had not been transcribed from the Eye Care Visit Note in April. Resident 17 should have received her eye drops as ordered by the Optometrist. 3.1-39(a)

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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, observation, and record review, the facility failed to address a resident's (Resident 26) pain by ensuring availability of pain medications and implementing other pain relief interventions for 1 of 1 resident reviewed for pain management. Findings include:The clinical record for Resident 26 was reviewed on 12/12/2025 at 1:30 p.m. The medical diagnoses included, but were not limited to, cancer and pneumonia.An admission minimum data set (MDS) assessment, dated 11/13/2025, indicated Resident 26 was cognitively intact, frequently had pain, utilized as needed pain medication, and the severity raised to a 9/10.A pain care plan, dated 11/23/2025, indicated that Resident 26 was at risk for pain and discomfort. The interventions included for staff to administer pain medications as ordered and the use of non-pharmacological relief of pain. During an observation and interview, on 12/09/2025 11:53 AM, Resident 26 was laying in bed. He was observed to be rubbing his right thigh frequently and having facial grimacing. Resident 26 indicated he was having pain at 8/10 and could not get pain medicine because the facility had run out of it. When asked the last dose of pain medicine, he said that evening and that he had asked for his narcotic pain medicine about 5:30 a.m. this morning for a pain of 7.5/10. Resident 26 stated] he hadn't had . anything to help with the pain but would try anything to take the edge off. During an interview and observation, on 12/9/2025 at 11:53 AM, LPN 8 confirmed that Resident 26 was out of pain medicine and stated, it is coming from pharmacy today. She administered Tylenol to Resident 26 for pain.A physician's order, dated 11/14/2025, indicated for Resident 26 to have narcotic pain medicine every four hours as needed for pain.Review of the Medication Administration Record for December 2025, indicated resident 26 utilized narcotic pain medicine as needed. He received a dose of narcotic pain medicine on 12/8/2025 at 10:20 PM.An Electronic Transmission Report, dated 12/11/2025, indicated that Resident 26's pain medicine was requested as reordered on 12/9/2025 at 12:00 PM.An email corresponded with Pharmacist 12 at Pharmacy 11, indicated the script was received electronically on 12/9/2025 at 4:04 PM.During an interview, on 12/12/2025 at 2:34 PM, the DON indicated staff should be reordering narcotics before residents run out, but at least when residents have at least a day of narcotics left.A policy entitled, Guidelines for Pain Management, was provided by the Executive Director on 12/10/2025 at 2:40 PM. The purpose of the policy to [provide residents the means to receive necessary comfort, exercise greater independence, and enhance their overall well-being. 3.1-37(a)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the availability of a resident's seizure medication for 1 of 6 unnecessary medications reviewed. (Resident 58)Findings include: The clinical record for Resident 58 was reviewed on 12/10/25 at 1:00 p.m. The resident's diagnoses included, but were not limited to, anoxic brain injury (brain deprived of oxygen), tracheostomy (airway in neck) and epilepsy. The resident was admitted to the facility on [DATE]. A physician's order, dated 12/9/25, indicated the resident was to receive 100 milligrams of lacosamide for seizures twice a day. The December 2025 Medication Administration Record (MAR) for Resident 58 indicated the following days and times the administration of 100 milligrams of lacosamide: -On 12/10/25 at 9:00 a.m. and 9:00 p.m., the medication was not available to be administered.-On 12/11/25 at 9:00 a.m. and 9:00 p.m., the medication was not available to be administered. -On 12/12/25 at 9:00 a.m., administered medication as ordered and at 9:00 p.m., the medication was not available to be administered.-On 12/13/25 at 9:00 a.m. and at 9:00 p.m., the medication was not available to be administered. -On 12/14/25 at 9:00 a.m., the medication was not available to be administered and at 9:00 p.m., the medication was administered as ordered.-On 12/15/25 at 9:00 a.m., the medication was not available to be administered and at 9:00 p.m., the medication was administered as ordered. -On 12/16/25 at 9:00 a.m., the medication was not available to be administered. A nursing progress note, dated 12/10/25 at 9:17 p.m., indicated the pharmacy needed a prescription for 100 milligrams of lacosamide. A nursing progress note, dated 12/11/25 at 10:56 a.m., indicated the medical provider and pharmacy were contacted. A prescription was needed and was sent in by the medical provider for 100 milligrams of lacosamide. A nursing progress note, dated 12/13/25 at 2:06 p.m., indicated the medical provider was notified for a prescription that was needed for 100 milligrams of lacosamide. The prescription was sent to the pharmacy and will be arriving STAT [As soon as possible]. A nursing progress note dated 12/14/25 at 2:41 a.m., Resident 58 has an order for 100 milligrams of lacosamide. Unfortunately, the medication has not arrived from pharmacy. The pharmacy was contacted by nursing asking why medication has not arrived; pharmacist states that they do not have a prescription for medication. At that time MD [medical doctor] was contacted and asked to send in script to pharmacy. MD stated that he did send the script, however when writer called pharmacy back, there was no sign of the prescription being sent on their end. Pharmacy states that they will not be able to send the medication until they receive a full correct prescription. Res [Resident] will be continually monitored and IS STABLE AT THIS TIME.Also res has no s/s [signs or symptoms] of distress. A nursing progress note, dated 12/14/25 at 12:25 p.m., indicated the pharmacy required the medical provider to send a prescription for the medication. The medical provider was contacted twice. An observation was made of the first-floor medication cart with the Director of Nursing (DON) on 12/16/25 at 9:13 a.m. Resident 58's 100 milligrams of lacosamide medication supply was not located in the medication cart. An interview was conducted with the DON on 12/16/25 at 9:20 a.m. He indicated Resident 58 was admitted on [DATE]. The facility's pharmacy was based out of Chicago, so STAT does not necessarily mean in a few hours the facility would receive medications that were coming STAT. He was unsure why the facility was not receiving the 100 milligrams of lacosamide for Resident 58. An interview was conducted with the DON on 12/16/25 at 12:40 p.m. He indicated Resident 58's MAR was incorrectly documented. Resident 58 has not received any dosages of 100 milligrams of lacosamide twice a day since ordered on admission, 12/9/25. He had contacted pharmacy that day. The pharmacy reported they still needed a prescription for the 100 milligrams of lacosamide medication. The DON had also contacted the medical provider. The medical provider reported the prescription had been sent over to the pharmacy multiple times. Resident 58's lacosamide medication was currently placed on hold by the provider until the arrival of the medication from the pharmacy. The staff were to monitor Resident 58 for seizures. 3.1-25(g)(1)(2)(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. Based on interview and record review, the facility failed to timely address a pharmacy recommendation to discontinue a resident's medications for 1 of 6 residents reviewed for unnecessary medications. (Resident 5) Findings include: The clinical record for Resident 5 was reviewed on 12/10/25 at 1:30 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD). A physician's order, dated 7/17/25, indicated Resident 5 was to receive 0.125 milligrams of hyoscyamine sulfate every 2 hours PRN (as needed). An October 2025 pharmacy recommendation indicated to discontinue unused PRN medications for Resident 5. The PRN 0.125 milligrams of hyoscyamine sulfate had not been used in the last 60 days. The pharmacy was recommending the medical provider to discontinue the medication. The medical provider as of 10/30/25 agreed to discontinue the medication. The November 2025 Medication Administration Record (MAR) indicated Resident 5 was able to receive 0.125 milligrams of hyoscyamine Sulfate every 2 hours PRN. A November 2025 pharmacy recommendation indicated to discontinue unused PRN medications for Resident 5. The PRN 0.125 milligrams of hyoscyamine sulfate had not been used in the last 60 days. The pharmacy was recommending the medical provider to discontinue the medication. The medical provider as of 12/9/25 agreed to discontinue the medication. The December 2025 MAR indicated Resident 5 was able to receive 0.125 milligrams of hyoscyamine sulfate every 2 hours PRN. An interview was conducted with the Director of Nursing (DON) on 12/11/25 at 2:40 p.m. He indicated the pharmacy recommendation in October and November to discontinue the PRN 0.125 milligrams of hyoscyamine sulfate for Resident 5 had not been discontinued in error. It was missed. 3.1-25(i)

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure residents received mechanically altered diets, as ordered by the physician, for 3 residents randomly observed at meal service (Resident 25, Resident 31, and Resident 36).Findings include: 1 a. The clinical record for Resident 31 was reviewed on 12/11/25 at 12:55 p.m. The resident's diagnosis included, but was not limited to, dementia. A physician's order, dated 12/4/23, indicated she was to receive a mechanical soft, ground meat texture diet. 1 b. The clinical record for Resident 25 was reviewed on 12/11/15 at 12:55 p.m. The resident's diagnosis included, but was not limited to, dysphagia (inability to swallow). A physician's order, dated 7/31/24, indicated she was to receive a mechanical soft, ground meat texture diet. 1c. The clinical record for Resident 36 was reviewed on 12/9/25 at 2:20 p.m. The resident's diagnosis included, but was not limited to, dysphagia. A physician's order, dated 7/22/25, indicated she was to receive a mechanical soft, chopped meat texture diet with nectar thick liquids. On 12/11/25 at 12:55 p.m., lunch service was observed in the second floor dining room. Resident 31, Resident 25, and Resident 36 were served plates with meatloaf, whole kernel corn, and mashed potatoes. Their meal tickets indicated they were to receive mechanical soft diets. During an interview on 12/11/25 at 2:50 p.m., the Dietary Manager (DM) indicated resident's with mechanical soft diets should have received the cream corn, not the whole kernel corn. During an interview on 12/12/25 at 9:38 a.m., the Therapy Coordinator indicated Resident 36 was to receive nectar thick liquids. On 12/12/25 at 11:10 a.m., Resident 36 was observed in the second floor dining room attending an activity. She had a cup of hot chocolate in front of her. When she drank the hot chocolate, she began to cough. During an interview on 12/12/25 at 11:12 a.m., Activity Assistant 20 indicated Resident 36's hot chocolate was not thickened. She was unsure if Resident 36's liquids needed to be thickened. 3.2-21(a)(3)

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	12/16/2025

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 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 ensure the residents' medical records were accurately documented for the administration of a resident's seizure medication and for the administration of a resident's eye drops for 1 of 6 unnecessary medications reviewed, 1 of 1 resident reviewed for vision services, and 1 or 3 reviewed for potential communication concerns. (Resident 58, Resident 17, and Resident 26) Findings include: 1.The clinical record for Resident 58 was reviewed on 12/10/25 at 1:00 p.m. The resident's diagnoses included, but were not limited to, anoxic brain injury (brain deprived of oxygen), tracheostomy (airway in neck) and epilepsy. The resident was admitted to the facility on [DATE]. A physician's order, dated 12/9/25, indicated the resident was to receive 100 milligrams of lacosamide for seizures twice a day. The December 2025 Medication Administration Record (MAR) for Resident 58 indicated the following days and times the administration of 100 milligrams of lacosamide: -On 12/12/25 at 9:00 a.m., the resident's lacosamide was documented as administered. -On 12/14/25 at 9:00 p.m., the resident's lacosamide was documented as administered. -On 12/15/25 at 9:00 p.m., the resident's lacosamide was documented as administered. An interview was conducted with the DON on 12/16/25 at 12:40 p.m. He indicated Resident 58's MAR was incorrectly documented 100 milligrams of lacosamide as administered on 12/12/25, 12/14/25, and 12/15/25. Resident 58 has not received any dosages of 100 milligrams of lacosamide twice a day since ordered on 12/9/25. 2. The clinical record for Resident 17 was reviewed on 12/9/25 at 11:45 a.m. The resident's diagnosis included, but was not limited to, glaucoma. A physician's order, dated 4/26/25, indicated she was to receive brimonidine tartrate ophthalmic solution 0.2 % 1 drop into both eyes two times a day for glaucoma. A Quarterly Minimum Data Set (MDS) Assessment, completed 11/28/25, indicated Resident 17 had moderately impaired cognition and severely impaired vision. During an interview on 12/09/25 at 11:45 a.m., Resident 17 indicated she had not received eye drops in a very long time. She had glaucoma and did not know why she was not receiving eye drops. On 12/10/25 at 9:45 a.m., Resident 17 was observed receiving her morning medications. Resident 17 did not receive eye drops from the nurse administering the medications. Resident 17 indicated she had not received eye drops in a long time. The November and December Medication Administration Record (MAR) indicated that the brimonidine tartrate ophthalmic solution 0.2 % had been given daily. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/25 at 11:05 a.m., Pharmacy Technician 21 indicated Resident 17 had not had a refill of the brimonidine tartrate ophthalmic solution 0.2 % sent to the facility since April 2025. During an interview on 12/11/25 at 11:45 a.m., the Director of Nursing indicated Resident 17 should have received her eye drops as ordered by the Optometrist. The eye drops should not have been signed of as given on the MAR if the resident did not receive them. 3. The clinical record for Resident 26 was reviewed on 12/12/2025 at 1:30 PM. The medical diagnoses included, but were not limited to, cancer and pneumonia. An admission minimum data set assessment, dated 11/13/2025, indicated Resident 26 was cognitively intact and did not have swallowing issues. A dental care plan, dated 11/23/2025, indicated Resident 26 was at risk for alternation in oral status. An intervention listen was to, .Observe for and report any chewing or swallowing problems. During an observation and interview, on 12/09/2025 11:53 AM, LPN 8 was noted to give Resident 26 multiple pills. Resident 26 indicated he could not swallow the pills and .the male nurse. crushed medication for him. LPN 8 stated she would need an order to crush medications, left the room with medication, retrieved pudding, then returned to administer pills whole in pudding. Resident 26 took two bites of pudding with pills, then reported he felt like the pills were stuck in his throat. LPN 8 instructed him to drink some water and left. Resident 26 indicated he had swallowing problems related to his radiation treatment for lung cancer. He was able to clear his throat about two minutes later. A physician's order, dated 11/13/2025, indicated crush medications for Resident 26 as needed. A nursing assessment, dated 12/9/2025, indicated Resident 26 did not have swallowing problems. During an interview, on 12/12/2025 at 2:34 PM, LPN 8 indicated the nursing note did not accurately reflect Resident 26's condition on 12/9/2025. When asked if she had reported the concerns, she said she told the next shift during report but did not report it to the physician or speech therapy. A policy entitled, MEDICAL RECORDS, was provided by the Nurse Consultant on 12/15/2025 at 10:14 AM. The policy indicated, .The American Health Information Management Association (AHIMA) guidelines are used as reference for clinical record management . The Standards of Ethics published by AHIMA, revised 2016, indicated for data to be encoded in a manner that was .accurate, complete, and consistent [with] coding practices . 3.1-50(a)(2)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview, observation, and record review, the facility should ensure the indwelling urinary catheter bag remains free of contact with the floor, that hand hygiene was performed prior to donning gloves, and that the hub of an insulin pen was disinfected prior to attaching the needle, for 1 or 1 residents reviewed for urinary catheters and 1 of 5 residents randomly observed during medication pass . (Resident 8 and Resident 1) Findings include:Findings include: 1.The clinical record for Resident 8 was reviewed on 12/11/2025 at 3:00 p.m. Medical diagnosis include, but were not limited to, a stroke. A Quarterly Minimum Data Set assessment, dated 11/11/2025, indicated Resident 8 was cognitively impaired and was frequently incontinent of bladder. A urological care plan, dated 11/12/2025, indicated Resident 8 had uropathy. Intervention included the use of a catheter. During an observation, on 12/09/2025 2:57 PM, Resident 8's indwelling urinary catheter bag was noted to be contacting the floor. During an observation, on 12/10/2025 1:21 PM, Resident 8's indwelling urinary catheter bag was noted to be contacting the floor. During an observation, on 12/15/25 at 12:29 PM, Resident 8's indwelling urinary catheter bag was noted to be contacting the floor. During an interview, on 12/15/25 12:41 pm, DON indicated that indwelling urinary catheter backs should not be contacting the floor. 2 .The clinical record for Resident 1 was reviewed on 12/10/25 at 11:51 a.m. The resident's diagnosis included, but was not limited to, diabetes. On 12/10/25 at 11:51 a.m., Licensed Practical Nurse (LPN) 26 was observed obtaining a blood sugar check and administering insulin to Resident 1. LPN 26 gathered the supplies from the medication cart. She performed hand hygiene using alcohol based hand gel and then reopened the medications cart to obtain an alcohol swab. She relocked the medication cart and went to Resident 1's room. LPN 26 knocked on the door and opened the door to enter the room. LPN 26 informed Resident 1 of the need to obtain a blood sugar. LPN 26 then donned gloves to obtain the blood sugar. She did not perform hand hygiene prior to donning the gloves. After obtaining the blood sugar, LPN 26 left Resident 1's room and returned to the medication cart. She performed hand hygiene and gathered the needed insulin supplies. She obtained an insulin pen from the medication cart, removed the lid of the insulin pen and attached a needle to the insulin pen. LPN 26 did not cleanse the hub of the insulin pen prior to attaching the needle. During an interview on 12/10/25 at 12:05 p.m., LPN 26 indicated she normally performed hand hygiene prior to donning gloves and the hub of the insulin pen should have been cleaned with alcohol prior to attaching the needle. 3.1-18(b)(1)