

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2013
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NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
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F000000	<p>This visit was for the Investigation of Complaint IN00137246.</p> <p>Complaint IN00137246 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F250 and F514.</p> <p>Survey dates: October 3, 4 and 7, 2013</p> <p>Facility number: 000149 Provider number: 155245 AIM number: 100266840</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 7 SNF/NF: 44 Total: 51</p> <p>Census payor type: Medicare: 6 Medicaid: 34 Other: 11 Total: 51</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F000000	Submission of this Plan of Correction shall not constitute or be construed as an admission by Castleton Health Care Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of Nursing Care and services to the residents of Castleton Health Care Center.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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	Quality review completed on October 14, 2013, by Brenda Buroker, RN.			

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review, the facility failed to ensure the social services staff followed the plan of care to ensure the attending physician was aware of behaviors of 2 of 3 residents which included verbal abuse of the staff and care refusals, and completed initial assessments and documentation of a newly admitted resident for 2 of 3 residents in a sample of 3 residents reviewed for care. (Resident #A and Resident #C)</p> <p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 10-3-13 at 5:45 p.m. His diagnoses included, but were not limited to, hypoxia, morbid obesity, tracheostomy, obstructive sleep apnea, high blood pressure, venous stasis ulcers of the lower extremities, cellulitis, chronic pain, urinary retention and bladder spasms.</p> <p>His admission Minimum Data Set (MDS) assessment, dated 7-29-13, indicated he was alert and oriented</p>	F000250	<p>I. Resident A: The Social Service Director has met with the resident and discussed his behaviors and if the resident is interested in counseling. The physician has been notified of the resident's behaviors, and resident's care plan was updated as applicable. Resident C: The resident has been seen by Social Service and appropriate documentation and assessments completed. II. All residents have the potential to be affected by the alleged deficient finding. A 100% audit will be completed for all residents by 11/6/13 to ensure Initial Social Service Assessments and documentation were completed and physician had been notified of any behaviors. A Social Service Assessment, documentation or physician notification of behaviors will be completed for any resident found to be lacking one or all of these elements. The Social Service Director was in-serviced on timely and thoroughness of documentation. III. Medical Records will complete Admission Chart Audits within 72 hours of admission and again 7 days after admission to ensure completion of assessments and</p>	11/06/2013	

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	<p>with no behavioral or mood disorders. It indicated he did not walk or leave his room.</p> <p>Review of the "Interdisciplinary Progress Notes," indicated on 8-16-13, the resident was refusing weekly weights, displaying "manipulative behaviors" with staff, was inappropriate with staff with sexually verbal comments and resisting care, but did not indicate what types of care. On 9-6-13, the notes indicated the resident had made false accusations regarding staff and had multiple complaints regarding the facility, both of which did not specify what the accusations or complaints were about. It indicated he was no longer working with therapy due to refusal of care.</p> <p>Review of the "Behavior/Mood/Psychotropic Tracking Record," indicated on 8-10-13 at 9:00 a.m., Resident #A made sexual comments regarding a dietary staff member which were relayed to the nurse on duty. Later the same day, at 11:25 a.m., it indicated the resident phoned the dietary department twice requesting his regular meal and a plate and silverware. When the same dietary staff member provided the requested</p>		documentation. IV. Results of the audits will be presented to the QA Committee during monthly QA Meetings to ensure completion.				

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	<p>items, the resident indicated he had purchased a meal from outside of the facility for her. The following day, the resident questioned why the same dietary staff member from the previous day did not visit him. The next entry, dated 9-28-13 at 5:00 p.m., indicated a CNA responded to his call light and request for assistance with toileting. The notes indicated the resident displayed behaviors of "screaming, hollering, inappropriate language" while care was attempting to be provided, as well as refusal for cleaning him up afterwards and changing the soiled linens. It indicated the nurse on duty was notified of these events.</p> <p>Review of Resident #A's care plan indicated on 8-13-13, and updated on 8-29-13, a concern with behavior problems of the resident being verbally abusive, sexually inappropriate and resistive to care. Interventions listed to address these issues included, but were not limited to, notification of the physician of such behaviors, investigation and monitoring the need for psychological support and providing such support as desired by the resident and discussing the behaviors, as possible with the resident.</p>				

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	<p>In interview with the Administrator on 10-3-13 at 5:25 p.m., he indicated Resident #A has "cussed out nearly every CNA," as well as being degrading and belittling to therapy staff. In interview with the Director of Nursing (DON) at the same time, she indicated this resident had refused care since admission and has yelled and degraded staff for following physician's orders.</p> <p>In interview with CNA #1 on 10-3-13 at 6:30 p.m., she indicated on 9-28-13, she was assisting CNA #2 with care for toileting with Resident #A. She indicated the resident yelled and cursed at both staff and refused to allow them to clean him up or change the soiled linens. She indicated she had been told by other staff of such behaviors, but this was the first time she had witnessed this behavior.</p> <p>In interview with CNA #2 on 10-4-13 at 2:17 p.m., she indicated she attempted to assist the resident with toileting, but needed additional help and obtained the assistance of CNA #1. She indicated during this time, she noted the linens under the resident were soiled with dried stool and informed the resident that upon completion of the toileting that she</p>			

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	<p>and the other CNA would get him cleaned up and change the linen. She indicated during the process of assisting the resident with toileting, he was "yelling and hollering and cussing something awful." She indicated the resident refused to allow the staff to clean him up or change the linens. She indicated she informed the nurse on duty, as well as the DON. CNA #2 indicated Resident #A did not display these types of behaviors upon initial admission, but has displayed them in the recent past.</p> <p>In interview with LPN #1 on 10-4-13 at 3:45 p.m., he indicated he has witnessed Resident #A yelling at staff, but not cursing at them. He indicated he was aware of the resident refusing care from staff.</p> <p>In interview with LPN #2 on 10-7-13 at 10:36 a.m., he indicated he had taken a phone call from Resident #A on the weekend of 9-28-13 and 9-29-13, between 8:00 p.m. and 9:00 p.m. in which the resident requested assistance to get cleaned up as he had refused assistance from a CNA earlier to get cleaned up. He indicated he did check on the resident and informed the nurse on duty of the resident's request. LPN #2 indicated it was a common event for the</p>				

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	<p>resident to refuse different types of care "until he is ready and then he wants it done right then, no matter what else the staff may be doing."</p> <p>In interview with Resident #A on 10-3-13 at 4:14 p.m., he indicated on 9-28-13, CNA #2 and another CNA assisted him with toileting. He indicated he did not want CNA #2 to clean him up related to past instances of care. He did not indicate he had raised his voice or cursed at the staff.</p> <p>Review of the "Social Service Progress Notes," indicated on 8-2-13, the resident refused oxygen tubing changes and on 9-20-13, it indicated he declined a nebulizer treatment with "no other behaviors observed or noted." There was no documentation the Social Services Designee (SSD) had notified the attending physician of any behaviors. There was no documentation the SSD had discussed any of the behaviors with the resident. There was no documentation the SSD had discussed counseling with the resident. A document entitled "Consent for Treatment and Billing," was provided by the Administrator on 10-7-13 at 12:15 p.m. This document indicated it was a consent for the services of the facility's psychiatrist</p>			

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	<p>and was dated 7-23-13. It was signed by the resident and a facility staff person and had a handwritten note on the document which indicated, "Decline."</p> <p>In interview with the Administrator on 10-7-13 at 11:40 a.m., he indicated the facility had been without a full time Social Services person for about 2 weeks, as he had let the previous SSD go. He indicated there has been a part time SSD assisting in the mean time. A new SSD began employment on 10-7-13.</p> <p>2. The clinical record for Resident #C was reviewed on 10-7-13 at 9:27 a.m. His diagnoses included, but were not limited to, paraplegia related to a motor vehicle accident, bowel resection with ileostomy, kidney failure, cardiomegaly and stage 4 decubitus to the sacrum. It indicated he was admitted to the facility on 9-17-13.</p> <p>Review of the Social Services notes indicated none were present. The only document present in the Social Services section was a document entitled, "Customary Routine/Social History." There were no assessments included in the "Social Services" section of the clinical record.</p>			

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	<p>On 10-7-13 at 2:25 p.m., the Administrator provided a copy of the facility's job description for the "Social Worker" position. This document indicated, "This position is responsible for the admission of patients to the center and coordinates center services to fulfil the patients' basic psychosocial needs as well as arranging for discharge of the patient at the appropriate time. Serves as center ombudsman...Duties and Responsibilities: Admit patients to center, following policies and procedures outlined by State, Federal and Company guidelines...Ensure that all records required to be filled out are done so completely, legibly and in a timely fashion..."</p> <p>3.1-34(a) 3.1-34(a)(1) 3.1-34(a)(2)</p>				

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F000514 SS=E	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure complete and accurate documentation of resident care records, specifically for ADL's (activities of daily living), meal consumption, bowel movements (BM) and fluid intake and output records, were maintained for 3 of 3 residents reviewed for care in a sample of 3. (Resident #A, Resident #B and Resident #C)</p> <p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 10-3-13 at 5:45 p.m. His diagnoses included, but were not limited to, hypoxia, morbid obesity, tracheostomy, obstructive sleep apnea, high blood pressure, venous</p>	F000514	<p>I. Resident A: the facility is unable to complete the missing documentation. Resident's food consumption records, ADLs, BM record, output will be recorded daily and audits completed to ensure compliance. The physician has been notified of residents behaviors and Social Services has discussed counseling with the resident. Resident B: the facility is unable to complete the missing documentation. Resident's food consumption records, ADLs, and BM record will be recorded daily and audits completed to ensure compliance. Resident C: the facility is unable to complete the missing documentation. Resident's food consumption records, ADLs, BM records and output will be recorded daily and audits completed to ensure compliance. II. All residents have</p>	11/06/2013	

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	<p>stasis ulcers of the lower extremities, cellulitis, chronic pain, urinary retention with an indwelling urinary catheter and bladder spasms.</p> <p>Review of Resident #A's "CNA ADL Tracking Form" for August, 2013 indicated 93 of 93 meal consumption records were undocumented. It indicated all aspects of ADL care were absent for 8-28-13 through 8-31-13, with the exception of receiving partial baths on those dates on the night shift. The "BM Record" for 8/13 indicated no documentation on the following dates: 8-7-13, 8-9-13, 8-10-13, 8-11-13, 8-13-13, 8-14-13, 8-18-13, 8-19-13, 8-23-13, 8-25-13 and 8-31-13.</p> <p>Review of Resident #A's "CNA ADL Tracking Form" for September, 2013 indicated 88 of 90 meal consumption records were undocumented. It indicated partial documentation of the resident's mobility for 9-1-13 through 9-28-13, with none documented on 9-29-13 and 9-30-13. It indicated personal hygiene assistance from 9-1-13 through 9-12-13, with no additional information for 9-13-13 through 9-30-13. It indicated the resident received partial baths on 9-1-13 through 9-5-13 and on 9-12-13, with no other information on</p>		<p>potential to be affected by the alleged deficient finding. Documentation cannot be completed after the fact, therefore, the facility is unable complete missing documentation. Nursing staff will be re-educated on 10/29/13, regarding completion of documentation. III. Daily audits of all residents ADL documentation, meal consumption, fluid intake and output will be completed by D.O.N./designee to ensure completion for 6 months. IV. Results of audits will be presented to the QA Committee during monthly QA Meetings to ensure compliance.</p>		

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	<p>bathing for the remainder of the month. It indicated the resident's bowel and bladder continency on 9-1-13 through 9-12-13, but no other information on this for the remainder of the month. The "BM Record" for 9/13 indicated no documentation on the following dates: 9-7-13, 9-8-13, 9-17-13, 9-18-13, 9-19-13, 9-23-13, 9-26-13, 9-27-13 and 9-31-13. Resident #A's output record for his indwelling urinary catheter for 9-13 had partial documentation of 2 of 3 shifts on 9-12-13, 9-15-13, 9-16-13, 9-17-13, 9-19-13 and 9-27-13. The output record for 9-13 with documentation for 1 of 3 shifts occurred on 9-21-13, 9-23-13, 9-25-13 and 9-26-13. Absence of output documentation was indicated on 9-24-13.</p> <p>Review of the "Social Service Progress Notes," indicated on 8-2-13, the resident refused oxygen tubing changes and on 9-20-13, it indicated he declined a nebulizer treatment with "no other behaviors observed or noted." There was no documentation the Social Services Designee (SSD) had notified the attending physician of any behaviors. There was no documentation the SSD had discussed any of the behaviors with the resident. There was no</p>						

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	<p>documentation the SSD had discussed counseling with the resident. A document entitled "Consent for Treatment and Billing," was provided by the Administrator on 10-7-13 at 12:15 p.m. This document indicated it was a consent for the services of the facility's psychiatrist and was dated 7-23-13. It was signed by the resident and a facility staff person and had a handwritten note on the document which indicated, "Decline." Other documentation in the clinical record indicated the resident had cursed multiple staff members, had made sexually oriented comments to staff members, had yelled at staff members, had refused personal hygiene care from staff, but this information was not referred to in the Social Services documentation.</p> <p>2. Resident #B's clinical record was reviewed on 10-4-13 at 10:06 a.m. His diagnoses included, but were not limited to CVA (cerebrovascular accident or stroke), high blood pressure, dementia, dysphagia with feeding tube and pulmonary hypertension. His dietary orders indicated he had a liquid feeding supplement via his gastrostomy tube for 22 hours daily at 70 milliliters per</p>			

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	<p>hour to run from 1:00 p.m. until 11:00 a.m. each day. Additionally, he was allowed soft foods and/or nectar thick fluids by mouth for oral gratification if provided by 100% supervision by facility staff and the resident was awake and alert.</p> <p>Review of the "CNA ADL Tracking Form" for September, 2013 indicated 90 of 90 meal consumption records were undocumented. It indicated partial documentation of the resident's mobility for 9-1-13 through 9-12-13, with none documented on 9-13-13 through 9-30-13. It indicated personal hygiene assistance from 9-1-13 through 9-12-13, with no additional information for 9-13-13 through 9-30-13. It indicated the resident received partial baths on 9-1-13 through 9-5-13 and on 9-12-13, with no other information on bathing for the remainder of the month. It indicated the resident's bowel and bladder continency on 9-1-13 through 9-12-13, but no other information on this for the remainder of the month. The "BM Record" for 9/13 indicated no documentation on the following dates: 9-4-13, 9-8-13, 9-17-13, 9-19-13, 9-23-13, and 9-31-13.</p> <p>3. The clinical record for Resident #C</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2013
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	<p>was reviewed on 10-7-13 at 9:27 a.m. His diagnoses included, but were not limited to, paraplegia related to a motor vehicle accident, bowel resection with ileostomy, gastrostomy tube for tube feeding, kidney failure, indwelling urinary catheter, cardiomegaly and stage 4 decubitus to the sacrum. It indicated he was admitted to the facility on 9-17-13.</p> <p>Review of the "CNA ADL Tracking Form" for September, 2013 indicated 18 of 39 meal consumption records were undocumented. It indicated partial documentation of the resident's mobility for 9-25-13 through 9-28-13, with none documented on 9-29-13 through 9-30-13. It indicated personal hygiene assistance from 9-17-13 through 9-24-13, with partial hygiene assistance documented from 9-25-13 through 9-28-13, with no additional information for 9-29-13 through 9-30-13. It indicated the resident received partial baths on 9-17-13 through 9-20-13 and on 9-23-13, with no other information on bathing for the remainder of the month. It indicated the resident's bowel and bladder continency on 9-18-13 through 9-28-13, but no other information on this for the remainder of the month. The "BM Record" for 9/13 indicated no documentation on</p>				

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	<p>the following dates: 9-17-13, 9-18-13, 9-19-13 and 9-31-13. Resident #A's output record for his indwelling urinary catheter for 9-13 had partial documentation of 2 of 3 shifts on 9-18-13, 9-19-13, 9-20-13, 9-21-13, 9-23-13, 9-24-13, 9-25-13, 9-27-13, 9-28-13, 9-29-13 and 9-30-13. The output record for 9-13 with documentation for 1 of 3 shifts occurred on 9-17-13. The resident's intake record for his tube feeding had incomplete documentation on 2 of 3 shifts on 9-17-13. It had incomplete documentation on 1 of 3 shifts on 9-18-13, 9-19-13, 9-20-13, 9-21-13, 9-23-13, 9-24-13, 9-26-13, 9-27-13, 9-28-13, 9-29-13 and 9-30-13.</p> <p>Review of the Social Services notes indicated none were present. The only document present in the Social Services section was a document entitled, "Customary Routine/Social History." There were no assessments included in the "Social Services" section of the clinical record.</p> <p>In interview with the Director of Nursing (DON) on 10-7-13 at 11:00 a.m., she indicated she was unaware of the lack of documentation related to ADL's.</p> <p>On 10-7-13 at 2:25 p.m., the DON</p>						

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	<p>provided a copy of a policy entitled, "Charting and Documentation." This policy indicated, "All services provided to the resident, or any changes in condition, shall be documented in the resident's clinical record..."</p> <p>On 10-7-13 at 2:25 p.m., the DON provided a copy of a policy entitled, "Charting ADL's." This policy indicated, "The facility shall maintain in the clinical record for each resident a daily chart of certified nursing assistant services provided to the resident. The certified nursing assistant who is caring for the resident must complete this record by the end of his or her shift. This record must indicate: assistance with activities of daily living, assistance with eating, assistance with drinking, each offering of nutrition, each offering of hydration...A licensed nurse shall review the documentation weekly and as needed."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			