

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 12/03/2014
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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 IN00159069.</p> <p>Complaint IN00159069- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: December 1, 2, and 3, 2014</p> <p>Facility number 000149 Provider number 155245 AIM number 100266840</p> <p>Survey team: Chuck Stevenson, RN</p> <p>Census bed type: SNF/NF: 48 Total: 48</p> <p>Census payor type: Medicare: 5 Medicaid: 33 Other: 10 Total: 48</p> <p>Sample: 3</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.3-1.</p>	F000000	<p>Submission of this Plan of Correction shall not constitute or be construed as an admission by Castleton Healthcare Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of nursing care and services to the residents at Castleton Healthcare Center. Castleton Healthcare center is requesting paper compliance.</p>	

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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F000279 SS=D	<p>Quality review completed on December 8, 2014 by Cheryl Fielden, RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a health care plan for a resident (Resident D) who suffered a fractured hip and returned to the facility following hip surgery. 1 resident of 3 reviewed for health care plans.</p> <p>Findings include:</p>	F000279	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? One resident was found to be affected by the deficient practice. On 12/8/14, Resident D's care plan was updated to include care plan related to hip fracture and any other diagnoses that will maintain the resident's highest practicable physical, mental, and</p>	01/02/2015

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	<p>The record of Resident D was reviewed on 12/02/14 at 1:40 P.M. Diagnoses included, but were not limited to, left hip fracture with open reduction and internal fixation, dementia, psychosis, osteoporosis, and depression.</p> <p>A significant change Minimum Data Set (M.D.S.) assessment dated 10/29/14 indicated Resident D was cognitively impaired, was depressed, required extensive to total staff assistance for activities of daily living, and was incontinent of bowel and bladder.</p> <p>A nurse's "Incident Note" dated 10/19/14 at 10:32 P.M., indicated "...pt (patient)...lying on the floor on left side of hip...Pt. states left hip hurt...Fire department came and took pt. to (name of acute care hospital)..."</p> <p>A physician's order dated 10/19/14 at 7:30 P.M., indicated "Send to ER (emergency room) for evaluation of fall."</p> <p>A nurse's "Admission Summary" dated 10/23/14 at 2:45 P.M., indicated "...Returned to facility from (name of acute care hospital)...was sent to (name of acute care hospital) on 10/19/14 for Eval. (evaluation) of (L) lower extremity; was admit'd (admitted) and Dx. (diagnosed): (L) (left) Hip Fx.</p>		<p>psychosocial well-being.</p> <p>2.How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken? All residents have the potential to be affected by thedeficient practice. An audit of all resident care plans will be reviewed byDON/Designee by 12/30/14 to ensure that current diagnoses will be residentspecific in care plans. All new admission care plan will be updated/implementedupon admission.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur? All resident care plans will be reviewed by the DON/Designee a minimumof quarterly to ensure completeness and accuracy. Any care plan found to beincomplete or inaccurate will be updated as appropriate by the DON/Designeeduring review. DON/Designee will conduct an audit of 3 random resident careplans per week for 6 months to ensure accuracy. Any issues will be addressed asappropriate.</p> <p>4.How will the corrective actions be monitored toensure the deficient practice will not recur? Results of the DON/Designee careplan audits will be presented to the QA Committee during monthly QA to ensurecompliance. Once 6 months of compliance is</p>				

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	<p>(fracture)...Resident has x3 (three) incisions to (LL) (left lower) extremity..."</p> <p>A "Social Services Note" dated 10/23/14 at 4:57 P.M., indicated "Resident readmitted on 10/22/14...readmitting dx (diagnoses) include L (left) hip fx ORIF (fracture with open reduction, internal fixation)..."</p> <p>A physician's order dated 10/31/14 indicated "Apply dressing to (symbol for "left") hip daily and PRN (as needed)."</p> <p>Resident D's record contained no health care plan related to the hip fracture and related open reduction, internal fixation surgery, including, but not limited to, weight bearing status, range of motion, elevation of extremity, use of heat or ice, or signs and symptoms of infection.</p> <p>During an interview on 12/03/14 at 10:30 A.M., the Director of Nursing (D.O.N.) indicated she had no additional documentation related to health care plans for Resident D.</p> <p>A facility policy titled "Comprehensive Care Plans" dated 8/14/2008 received from the D.O.N. on 12/03/14 at 9:45 A.M. indicated: "The facility shall develop a comprehensive care plan for each resident. The comprehensive care</p>		<p>achieved, QA Committee will determine if further auditing is necessary.</p>	

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F000514 SS=D	<p>plan shall include: Measurable objectives and timetables to meet a residents Medical needs, Nursing needs, Psychosocial needs. Describe services to be furnished to the resident to attain or maintain the resident's highest practicable Physical, Mental, Social well-being."</p> <p>3.1-35(a)</p> <p>483.75(l)(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 record review and interview, the facility failed to maintain complete and accurate medical records for 1 resident (Resident C) of 3 residents reviewed for complete and accurate medical records.</p> <p>Findings include:</p>	F000514	<p>1.What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice? Oneresident was found to be affected by the deficient practice. Resident C's recapitulatonsorders were updated immediately and diagnoses were added.</p>	01/02/2015

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	<p>The record of Resident C was reviewed on 12/02/14 at 10:00 A.M. Diagnoses included, but were not limited to, Alzheimer's Disease with behavioral disturbance, congestive heart failure, diabetes mellitus, psychosis, chronic bilateral lower extremity edema, constipation, anxiety, and chronic pain.</p> <p>A quarterly Minimum Data Set (M.D.S.) assessment dated 10/17/14 indicated Resident C was unable to complete a cognitive status evaluation, and staff evaluation indicated Resident C was severely cognitively impaired. Resident C was totally dependent on staff for all activities of daily living, and was incontinent of bowel and bladder.</p> <p>Resident C's "Recapitulation of Physician's Orders" for November 2014 and December 2014 contained no comprehensive list of diagnoses for Resident C.</p> <p>During an interview on 12/03/14 at 10:30 A.M., the Director of Nursing (D.O.N.) indicated she had no additional documentation to provide related to Resident C's Recapitulation of Physician's Orders for November or December 2014.</p>		<p>2.How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken? All residents have the potential to be affected by thedeficient practice. The DON/Designee will review all resident physician ordersfor new diagnosis by 12/30/14 to ensure completeness and accuracy. Any orderfound to be incomplete or inaccurate will be clarified as appropriate.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur? Licensed nursing staff will be in-serviced on complete and accurate recapitulationphysician orders with diagnosis by 12/18/14. DON/Designee will monitor all newphysician orders for diagnosis 5 days per week for completeness and accuracy andreCAPITULATIONS physician orders monthly for 6 months and on an ongoing basisat clinical meetings. Any order found to be incomplete or inaccurate will beclarified as appropriate.</p> <p>4.How will the corrective actions be monitored toensure the deficient practice will not recur? Results from daily physicianorder review will be presented by DON/Designee to QA Committee during monthlyQA Committee Meeting. Once 6 months of compliance is achieved, QA</p>	

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	A facility policy titled "Clinical Records" dated 10/24/2011 and received from the D.O.N. on 12/02/14 at 1:30 P.M., indicated "The facility will maintain accurate, complete and organized clinical information about each resident that is readily accessible for resident care." 3.1-50(a)(1) 3.1-50(a)(2)		Committeewill determine if further auditing is necessary.		