

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  01/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 22, 23, 24, 25, 28, 29, and 30, 2013</p> <p>Facility number: 000149 Provider number: 155245 AIM number: 100266840</p> <p>Survey team: Karina Gates, BHS TC Courtney Mujic, RN Beth Walsh, RN</p> <p>Census bed type: SNF: 9 SNF/NF: 43 Total: 52</p> <p>Census payor type: Medicare: 11 Medicaid: 35 Other: 6 Total: 52</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 2/06/13 by Suzanne Williams, RN</p>	F0000	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.	

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.

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  01/30/2013
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the MD (medical doctor) of a hypoglycemic (low) blood sugar level for 1 of 3 residents reviewed for MD</p>	F0157	It is the intent of this facility to immediately inform the resident; consult with the residents physician; and if known, notify the resident's legal representative or an interested family member	03/01/2013	

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  01/30/2013	
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>notification. (Resident #65)</p> <p>Findings include:</p> <p>The clinical record for Resident #65 was reviewed on 1/24/13 at 11:00 a.m. The diagnosis for Resident #65 included, but was not limited to: diabetes mellitus</p> <p>During an interview with Resident #65, on 1/23/13 at 1:38 p.m., the Resident indicated he had a very low blood sugar earlier in the week and he thought the facility did not notify the MD about it. He indicated he thought this because he asked about getting new insulin orders to ensure the low blood sugar doesn't happen again because the situation can turn dangerous. Resident #65 indicated when he said this, a staff member told him, they (the facility) needed to wait to talk to the NP (Nurse Practitioner) later in the week about new insulin orders, when she was here (at the facility).</p> <p>A review of the Nurse's Notes, dated 1/19/13, indicated Resident #65 had a blood sugar of 39 (hypoglycemic) at 9:50 p.m. Milk and juice were provided and the blood sugar was rechecked at 10:00 p.m. and was 53 (hypoglycemic). Food and milk were</p>		<p>when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #65 no longer resides in facility. 2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. Licensed nursing staff were in-serviced on physician notification and hypoglycemic protocol on 2/12/13. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? D.O.N./designee will monitor accu check results daily to ensure</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  01/30/2013
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>provided again. The resident's blood sugar was 96 at 10:30 (p.m.). MD notification, of the hypoglycemic blood sugars, was not located in the clinical record.</p> <p>A review of the Admission Physician's Orders indicated the MD was to be notified if a blood sugar level was less than 70 or greater than 350.</p> <p>A review of the Accucheck Log, indicated the MD was to be notified if the blood sugar level was less than 70 or greater than 350.</p> <p>In an interview with LPN #5, on 1/24/13 at 11:28 a.m., she indicated each resident had a specific "call order," if the resident was hypoglycemic/hyperglycemic. The orders would indicate when the MD should be called and it was written on top of the Accucheck Log, as well.</p> <p>On 1/24/13 at 11:30 a.m., the DoN (Director of Nursing) indicated the nurse would've written, in the nurse's notes, that the MD was notified of the low blood sugar levels. She also indicated she was unable locate a MD notification, of the low blood sugars, in clinical record. The DoN indicated the MD should have been notified of the low blood sugars because the</p>		<p>physician notification as appropriate, for 6 months. Any accu check results requiring physician notification found without notification will be reported immediately. Any nurse found to be out of compliance will be re-educated. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur i.e., what quality program will be put into place? Results of the accu check audits will be presented by the D.O.N./designee to the QA Committee during monthly QA Meetings to ensure compliance. Once 6 months of compliance is achieved, the QA Committee will determine if further auditing is necessary.</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  01/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>results were outside of the parameters of the call order/Physician's Order.</p> <p>3.1-5(a)(2)</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  01/30/2013	
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained in relation to being dressed in a hospital gown for 1 of 1 resident reviewed for dignity. (Resident #3.)</p> <p>Findings included:</p> <p>Resident #3's clinical record was reviewed on 1/28/2013 at 10 a.m. Diagnoses included, but were not limited to; anoxic brain injury, bilateral foot drop.</p> <p>A care plan titled, "Activities of Daily Living (ADLs)-Self Care Deficit," dated 11/26/2012, indicated, "Problem, Need, Strength, Potential Concern: Resident is at risk of developing complications R/T (related to) the needing total assistance in the following ADLs: bed mobility, transfer, locomotion, dressing. Approach: Out of bed daily in appropriate chair. Provide tilt-in space w/c (wheel chair), full padded sc (seat cushion)."</p>	F0241	<p>It is the intent of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #3 is up in wheel chair, dressed appropriately daily. 2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All dependent residents have the potential to be affected by the alleged deficient practice. Nursing staff were in-serviced on resident dignity on 2/12/13. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? D.O.N./designee will perform dignity rounds to ensure residents are dressed appropriately. Rounds will be completed daily M-F for 6 months. Any resident found to be inappropriately dressed will be corrected immediately and</p>	03/01/2013			

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  01/30/2013
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>During observations of Resident #3, he was wearing a 'hospital gown' while lying in bed on 1/22/2013 at 1:21 pm, and on 1/29/2013 at 12:25 pm.</p> <p>An interview with CNA #5 on 1/29/2013 at 1:11 pm indicated she doesn't usually work on this unit, but the resident is gotten up and fully dressed in regular clothes at least once every other day so he can sit up in the wheelchair out in the assisted dining room. She did not get him up today, but she put him in a clean hospital gown.</p> <p>An interview with the Director of Nursing on 1/30/13 at 12:50 pm indicated it is the expectation that this resident is gotten up daily, but even if not gotten up out of bed, he will be dressed in clothes other than a hospital gown.</p> <p>3.1-3(t)</p>		<p>staff re-education performed. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? Results of dignity rounds will be presented by the D.O.N./designee to the QA Committee during monthly QA Meeting to ensure compliance. Once 6 months of compliance is achieved, QA Committee will determine if further auditing is necessary.</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  01/30/2013	
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0278 SS=A	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to document an accurate assessment, related to falls, on the MDS (Minimum Data Set) assessment, for 1 of 14 residents reviewed for MDS assessment accuracy. (Resident #54)</p>	F0278	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #54's was modified on 2/8/13. 2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what</p>	03/01/2013			

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  01/30/2013
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p><b>Findings include:</b></p> <p>The clinical record for Resident #54 was reviewed on 1/25/13 at 1:30 p.m. The diagnoses for Resident #54 included, but were not limited to: dementia, muscle weakness, and pulmonary fibrosis.</p> <p>The admission MDS assessment, dated 12/31/12, indicated Resident #54 had not fallen since admission.</p> <p>A review of a Patient Incident Investigation, dated 12/26/12, indicated Resident #54 had a fall on 12/26/12 at 9:45 p.m.</p> <p>During an interview with the DoN (Director of Nursing), at 12:25 p.m., on 1/28/13, she indicated the MDS coordinator just resigned from the facility and was unsure why the admission MDS would say there wasn't a fall, when the Resident actually did have a fall that happened after admission.</p> <p>On 1/28/13 at 1:00 p.m., the MDS Coordinator indicated she was new to the position and was unsure why the previous MDS Coordinator documented there were no falls for Resident #54, when in fact he had a fall in the look-back period for the</p>		<p>corrective action(s) will be taken? All residents experiencing a fall have the potential to be affected by the alleged deficient practice. Any resident having a fall in past 30 days will have their MDS audited to ensure accuracy of coding for falls. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? MDS Coordinator that completed the incorrect MDS for resident #54 is no longer with the facility. New MDS Coordinator is aware of regulations pertaining to MDS coding of falls. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur i.e., what quality program will be put into place? MDS Coordinator/designee will present the Quality Measure Report to the QA Committee during monthly QA Meeting to ensure coding compliance. QM Report will be compared to Incident/Accident log to ensure any fall was coded. Any resident with a fall not identified on the MDS will have their MDS modified. Once 6 months of compliance is achieved, QA Committee will determine if further auditing is necessary.</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  01/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	admission MDS assessment. She also indicated the MDS was incorrect.  3.1-31(d) 3.1-31(i)			

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  01/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	<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 observation, interview and record review, the facility failed to develop a skin integrity care plan for a resident with skin integrity issues and a range of motion care plan for a resident's range of motion impairment, for 2 of 28 residents reviewed for care plan development. (Resident #18 and #3)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #18 was reviewed on 1/25/13 at 11:00 a.m.</p>	F0279	It is the intent of this facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #18 had a Care Plan written for fragile skin on 1/28/13. Resident #3's Care Plan was updated to include PROM on 1/31/13. 2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All resident Care	03/01/2013

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  01/30/2013
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The diagnoses for Resident #18 included, but were not limited to: dementia and bipolar disorder.</p> <p>An observation of Resident #18 was made on 1/28/13 at 12:35 p.m. She had an area covering the top of her right hand that was mostly dark purple in color, but a yellowish green color towards the wrist. The entire area was the size of 3/4 of a dollar bill and extended into the knuckle area.</p> <p>During review of Resident #18's care plans, no care plan for non-pressure related skin integrity could be found.</p> <p>An observation of the area on Resident #18's right hand was made with the DON (Director of Nursing) on 1/28/13 at 1:30 p.m. The DON indicated she noticed the area "a couple weeks ago". She looked through Resident #18's care plans and indicated Resident #18 should have a skin integrity care plan, but that she didn't see one for her.</p> <p>At 1:55 p.m. on 1/28/12, the DON provided a "Fragile Skin" care plan for Resident #18 dated 1/28/13. She stated, "I went ahead and care planned her fragile skin."</p> <p>2. Resident #3's clinical record was</p>		<p>Plans were reviewed by the IDT. Residents with impaired skin integrity and the need for ROM were updated as appropriate. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? All resident care plans will be reviewed by the IDT a minimum of quarterly to ensure completeness and accuracy. Any care plan found incomplete or inaccurate will be updated as appropriate by the IDT during review. D.O.N./designee will conduct an audit of 3 random resident's Care Plans per week for 6 months to ensure accuracy. Any issues will be addressed as appropriate. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? Results of D.O.N./designee Care Plan audits will be presented to the QA Committee during monthly QA Meeting to ensure compliance. Once 6 months of compliance is achieved, QA Committee will determine if further auditing is necessary.</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  01/30/2013	
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>reviewed on 1/28/2013 at 10 a.m. Diagnoses included, but were not limited to; anoxic brain injury, bilateral foot drop.</p> <p>During an observation of Resident #3 on 1/22/2013 at 1:20 p.m., the resident's left and right hands appeared to be slightly contracted.</p> <p>Interview with Occupational Therapist #6 on 1/29/2013 at 1 pm indicated he does have slight wrist contractures, but he is resistant to care. She assessed him for therapy last in maybe December, but he could not participate because he was resistant, he squirms a lot and he swears constantly. He responds poorly to touch. He has a device on his wheelchair called a foot stop that will prevent him from further foot drop.</p> <p>During observation of the resident on 1/29/2013 at 1:13 p.m., his wheelchair had the foot drop device in place.</p> <p>No plans of care related to the resident's range of motion could be found in the clinical record. An interview with the Director of Nursing on 1/28/2013 at 2:46 pm indicated no care plans could be found, because Resident #3 is not currently receiving</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  01/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	restorative nursing services for range of motion.  3.1-35(a) 3.1-35(b)			

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  01/30/2013
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update a nutrition care plan to reflect changes in approaches and failed to update care plans with interventions for psychotropic medication use/behaviors and fall prevention, for 3 of 28 residents reviewed for care plans. (Resident #60, #38 and #54)</p> <p>Findings included:</p> <p>1. Resident #60's clinical record was reviewed on 1/25/2013 at 1:05 pm. Diagnoses included, but were not limited to; schizoaffective disorder, chronic pain.</p>	F0280	<p>It is the intent of this facility to develop within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. 1. What corrective action(s) will be accomplished for those residents</p>	03/01/2013	

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  01/30/2013	
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>A dietary progress note, dated 1/15/2013, indicated, "Nutritional note. Re-weigh obtained and recorded as 176.1, writer asked about weight procedures, and was told resident's weight obtained was done by hoyer and all previous weights done by wheelchair weight. Writer to request for weight to be obtained the same way for accuracy."</p> <p>A care plan titled, 'Nutrition,' and most recently dated 1/28/2013, indicated, "Problem, Need, Strength, Potential Concern: Resident to be weighed via wheelchair for accuracy. Approach: Weigh and monitor results: monthly and prn, weekly."</p> <p>An interview with the Dietary Manager on 1/28/13 at 1:40 pm indicated the correct way to weigh this resident from now on is in her wheelchair. Also, now that the resident's weight has been determined to be stable, she should only be weighed monthly, not weekly.</p> <p>Interview with the Dietary Manager on 1/30/2013 at 11:45 am indicated she updates the care plans right away. She did add to the care plan on 1/28/2013 that the resident should only be weighed by wheelchair.</p>		<p>found to have been affected by the alleged deficient practice? Resident #60's Care Plan was updated on 2/8/13 as appropriate and now receives weights monthly and PRN. Resident #38's Care Plan was updated on 1/28/13 to reflect appropriate labs. Resident #54's Care Plan was updated on 1/28/13 to reflect use of personal alarms. 2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All resident Care Plans were reviewed by the IDT for appropriate interventions and updated as appropriate. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? All resident care plans will be reviewed by the IDT a minimum of quarterly to ensure completeness and accuracy. Any care plan found incomplete or inaccurate will be updated as appropriate by the IDT during review. D.O.N./designee will conduct an audit of 3 random resident's Care Plans per week for 6 months to ensure accuracy. Any issues will be addressed as appropriate. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?</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  01/30/2013
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. The clinical record for Resident #38 was reviewed on 1/25/13 at 1:00 p.m. The diagnoses for Resident #38 included, but were not limited to: agitation, presenile dementia with delusion and behavioral disturbances, and schizophrenia.</p> <p>A review of the January Physician's Orders, indicated a depakene lab (medication level lab), AST/ALT lab (liver lab), and lithium level lab (medication level lab) were to be drawn every three months.</p> <p>During a review of the a psychotropic drug use care plan, dated 11/15/12, and a behavior care plan, dated 11/15/12, lab order interventions were not located on either care plan.</p> <p>During an interview with the DoN (Director of Nursing), on 1/28/13 at 2:25 p.m., she indicated lab orders should be on the care plan for either psychotropic drug use or behaviors. She indicated she was unsure why the lab orders were not on either care</p>		Results of D.O.N./designee Care Plan audits will be presented to the QA Committee during monthly QA Meeting to ensure compliance. Once 6 months of compliance is achieved, QA Committee will determine if further auditing is necessary.		

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  01/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>plan.</p> <p>At 2:29 p.m., on 1/28/13, the DoN indicated she just added the lab orders, as an intervention, to a care plan and it was a collaborative effort by the entire facility to ensure care plans were updated appropriately.</p> <p>3. The clinical record for Resident #54 was reviewed on 1/25/13 at 1:30 p.m. The diagnoses for Resident #54 included, but were not limited to: dementia, muscle weakness, and pulmonary fibrosis.</p> <p>A review of a Incident Report, dated 12/26/12, indicated Resident #54 had a fall on 12/26/12 at 9:45 p.m. The report also indicated chair and bed alarms were to be applied, as a new intervention, to prevent another fall.</p> <p>A review of the Fall Care Plan, dated 1/4/13, indicated there was no intervention/approach for bed and chair alarms.</p> <p>During an interview with DoN (Director of Nursing), on 1/28/13 at 12:25 p.m., she indicated if there were new interventions for a care plan, the intervention should be on the care plan. The DoN indicated she was unsure why the alarms</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  01/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>intervention was not on the care plan, even though the care plan was dated after the Resident's fall on 12/26/12. She also indicated the bed and chair alarms interventions should be on the care plan and she would add them at that time.</p> <p>A review of the Fall care plan, dated 1/4/13, indicated an intervention of chair and bed alarms was added and the placement and function of each, should be checked each shift. The hand written intervention was dated 1/28/13.</p> <p>3.1-35(d)(2)(B)</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  01/30/2013
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to accurately asses a resident's skin condition for 1 of 1 resident reviewed for non-pressure related skin conditions. (Resident #18)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #18 was reviewed on 1/25/13 at 11:00 a.m.</p> <p>The diagnoses for Resident #18 included, but were not limited to: dementia and bipolar disorder.</p> <p>The 11/21/12 quarterly MDS (minimum data set) assessment indicated Resident #18 was totally dependent on one person for dressing, personal hygiene and toilet use. It indicated her BIMS (brief interview for mental status) score was a 7, indicating Resident #18 was cognitively impaired.</p>	F0309	<p>It is the intent of this facility that each resident receive and the facility provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #18 was seen by Nurse Practioner on 1/30/13 and assessment of hand was documented. 2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? Any resident with a non-pressure related skin condition has the potential to be affected by the alleged deficient practice. All residents will receive skin assessments by 2/20/13. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? All licensed nurses were in-serviced on skin</p>	03/01/2013	

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  01/30/2013	
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>An observation of Resident #18 was made on 1/28/13 at 12:35 p.m. She had an area covering the top of her right hand that was mostly dark purple in color, but a yellowish green color toward the wrist. The entire area was the size of 3/4 of a dollar bill and extended into the knuckle area.</p> <p>Review of the 1/23/13, 1/16/13, 1/9/13, and 1/2/13 skin assessments did not indicate this area on Resident #18's right hand.</p> <p>An observation of the area on Resident #18's right hand was made with the DON (Director of Nursing) on 1/28/13 at 1:30 p.m. The DON indicated, "It doesn't look trauma related. I think it's a condition with the elderly when their skin is more fragile. Yes, it was purple and I'm not saying there isn't blood under there. I noticed it a couple weeks ago."</p> <p>Another observation of Resident #18's right hand was made on 1/30/13 at 12:39 p.m. The area was still purple in color, but smaller than it was two days prior. The yellowish green color towards the wrist area was no longer present.</p> <p>During an interview with the Nurse Practitioner on 1/30/13 at 1:22 p.m.,</p>		<p>assessments on 2/12/13. Weekly skin assessments will be reviewed by D.O.N./designee for accuracy and appropriate follow-up for 6 months. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? D.O.N./designee will present wound/skin report to QA Committee during monthly QA Meeting to ensure completion and appropriate follow-up. An Action Plan will be initiated for any identified trends. Once 6 months of compliance is achieved, QA Committee will determine if further auditing is necessary.</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  01/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>she indicated, "I saw the area on her right hand. Near the knuckles it was grayish green. It was purple towards the wrist area. She definitely has some discoloration in there." When interviewed regarding whether she could say with certainty that it was not a bruise, she replied with, "I have to call it something and I'm going to call it discoloration and frailty. It was not there the last time I saw her."</p> <p>3.1-37(a)</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  01/30/2013	
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to provide a resident with a bed alarm as ordered following a fall with hospitalization, for 1 of 3 residents reviewed for accidents of 6 who met the criteria for accidents. (Resident #18).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #18 was reviewed on 1/25/13 at 11:00 a.m.</p> <p>The diagnoses for Resident #18 included, but were not limited to: dementia and bipolar disorder.</p> <p>The 1/10/13, 12:00 p.m. nurses note indicated Resident #18 was "found on floor" in her room at 12:00 noon. "She was laying next to bed face down w/left side of face on floor. res (resident) responded immediately when i called her name. res was slowly turned over to back and pillow...received no (new order) also</p>	F0323	<p>It is the intent of this facility that the resident environment remain as free of accident and hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #18 has a bed alarm in place while in bed. 2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? Any resident with a bed alarm has the potential to be affected by the alleged deficient practice. All bed alarms are checked for placement and function every shift and documented by licensed nursing staff. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? All nursing staff were in-serviced on bed alarm placement on 2/12/13. D.O.N./ designee will perform random audits of appropriate bed alarm placement for 6 months.</p>	03/01/2013			

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  01/30/2013	
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>to send out to er (emergency room) d/t (due to) co (complains of) head ache and spinal pain."</p> <p>The 1/10/13, 2:30 p.m. nurses notes indicated, "hosp (hospital) nurse called to inform us that res will be returning to facility ct scan to face/head was negative of fractures...nurse stated did not feel xray of spine needed."</p> <p>The 1/11/13 incident report indicated, "Res found by nurse @ 12 noon on floor by the side of her bed, layin (sic) face down w/(symbol for "left") side of face on floor. Resident responded immediately when I called out her name She stated that she was trying to transfer to bed &amp; "got dizzy" &amp; fell when asked." The incident report indicated Resident #18 was taken to the hospital by the ambulance on 1/10/13 at 12:30 p.m. The "Additional Comments and/or Steps Taken to Prevent Recurrence" section of the report indicated, "Sent to ER (name of hospital) for further eval (evaluation) &amp; treat (treatment) / Bed &amp; chair alarms."</p> <p>The 1/10/13 Patient Incident Investigation indicated, "Patient will benefit from a bed/chair alarm. Actions taken now to prevent</p>		<p>Any identified issues will be addressed immediately. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? Results of audits will be presented to the QA Committee by the D.O.N./designee during monthly QA Meetings. An Action Plan will be initiated for any identified trends. Once 6 months of compliance is achieved, QA Committee will determine if further auditing is necessary.</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  01/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>recurrence? reminder &amp; w/c &amp; bed alarm placed."</p> <p>The 11/27/12 Falls care plan indicated an approach was "Provide environmental adaptations: Call light within reach". Another approach dated 1/10/13 was "Bed &amp; w/c alarms."</p> <p>On 1/28/13 at 12:35 p.m. an observation was made of Resident #18 sitting in her wheelchair eating lunch. The call light cord was observed leading underneath a pillow in a red chair, 6 feet away from her. The actual call light was not visible and not within Resident #18's reach. No bed alarm could be found.</p> <p>An observation of Resident #18 in her room eating lunch was made with CNA #4 twelve minutes later on 1/28/13 at 12:47 p.m. CNA #4 stated, "She's never had a bed alarm since I got here in April. Her call light is over here in the chair." The call light was observed 6 feet away from Resident #18 completely underneath a pillow in a red chair. CNA #4 lifted the pillow, picked up the call light, walked over to Resident #18, and attached the call light to her shirt.</p> <p>An interview was conducted with the</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  01/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>ADON (Assistant Director of Nursing) on 1/28/13 at 1:00 p.m. regarding whether Resident #18 was supposed to have a bed alarm. The ADON looked in Resident #18's medical chart and pointed to a 1/10/13 M.D. order that indicated, "- may send resident out to ER for further eval (evaluation) &amp; treat (treatment) - place bed &amp; chair alarm, check q (every) shift."</p> <p>3.1-45(a)(2)</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  01/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to consider having labs drawn to monitor liver function for 2 of 5 residents reviewed on Depakote usage of 10 reviewed for unnecessary medications. (Residents #54 and #20)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #54 was reviewed on 1/25/13 at 1:30 p.m. The diagnoses for Resident</p>	F0329	It is the intent of this facility that each resident's drug regimen must be free from unnecessary drugs. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #54 recieved an LFT lab on 1/31/13 and results were within normal limits. Resident #20 recieved an LFT lab on 1/31/13 and results were within normal limits. 2. How other residents having the potential to be affected by the same alleged deficient practice	03/01/2013

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  01/30/2013
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p><b>#54 included, but were not limited to: acute encephalopathy, dementia, muscle weakness, and pulmonary fibrosis.</b></p> <p>A review of a Physician's Order, dated 1/9/13, indicated Depakote Sprinkles (medication used for behaviors) 125 mg (milligram) was to be given daily at 2:00 p.m.</p> <p>A review of a Behavior Care Plan, dated 12/31/12, indicated Resident #54 had behaviors of resisting care.</p> <p>In a review of the Physician's Orders, after the above order written on 1/9/13, there was no order located for a liver function test (a lab drawn to determine liver function) or AST/ALT (labs to determine issues with the liver) lab.</p> <p>A Physician's Order, dated 1/30/13, was received by the DoN (Director of Nursing) on 1/30/13 at 12:30 p.m., indicating a LFT (liver function test) was to be drawn on 1/31/13 and then every 6 months.</p> <p>2. The clinical record for Resident #20 was reviewed on 1/25/13 at 12:30 p.m.</p>		<p>will be identified and what corrective action(s) will be taken? Any resident receiving Depakote has the potential to be affected by the alleged deficient practice. Medical Records for all residents receiving Depakote were reviewed to ensure appropriate lab test were ordered. Physicians were notified and orders obtained as appropriate. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? D.O.N./designee will review new physician orders daily M-F to ensure appropriate labs are ordered for any resident beginning Depakote regimen. Physician's will be notified and orders requested as appropriate. Daily review will be ongoing. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? D.O.N./designee will report results of physician orders audit to QA Committee during monthly QA Meeting to ensure compliance. Once 6 months of compliance is achieved, results of audits will not be presented to the QA Committee, however, daily review of physician orders will continue (M-F) on an ongoing basis.</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  01/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The diagnoses for Resident #20 included, but were not limited to: Alzheimer's dementia with delusions &amp; behavioral disturbances, and psychosis.</p> <p>The January 2013 physician's recapitulation orders indicated "Divalproex Cap 125 mg (For: Depakote Sprinkles) One capsule by mouth twice daily." The original order date was 12/19/12.</p> <p>In a review of the physician's orders after the above 12/19/12 original order, there was no order located for a liver function test (a lab drawn to determine liver function) or AST/ALT (labs to determine issues with the liver) lab.</p> <p>On 1/30/13 at 12:30 p.m. the DON (Director of Nursing) provided an order, dated 1/30/13, that indicated, "LFT x1 then q (every) 3 months (symbol for "with") Depakote level."</p> <p>An Interview with the Director of Nursing on 1/30/2013 at 10:40 am indicated they just follow the MD's orders when a resident is put on Depakote. They don't suggest a liver function test if it's not ordered.</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  01/30/2013
NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	A PDR Nurse's drug handbook (2013 Edition) indicated for Depakote, "Nursing considerations: Assessment: Assess for hepatic (liver) dysfunction...Monitoring: Monitor for hypersensitivity reactions, pancreatitis, hepatotoxicity..."  3.1-48(a)(3)				