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 10/21/2014

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

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F000000	This visit was for the Investigation of Complaints IN00158007 & IN00156884. This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 9/12/14 . Complaint IN00158007-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00156884-Substantiated. Federal/State Deficiencies related to the allegations are cited at F-241. Survey dates: October 20 & 21, 2014. Facility number: 000149 Provider number: 155245 AIM number: 100266840 Survey Team: Beth Walsh, RN-TC Karina Gates, Generalist Tom Stauss, RN Census bed Type: SNF: 2 NF: 36 NCC: 14 Total: 52	F000000	Submission of this Plan of Correction shall not constituteor be construed as an admission by Castleton Healthcare Center that theallegations contained in the survey report are accurate or reflect accuratelythe provisions of nursing care and services to the residents at CastletonHealthcare Center. Castleton Healthcare Center is requesting paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Census payor Type: Medicare: 2 Medicaid: 36 Other: 14 Total: 52 Sample: 7 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 23, 2014 by Cheryl Fielden, RN.			
F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. Based on observation, interview, and record review, the facility failed to ensure a resident was treated with dignity/respect for 1 of 3 residents reviewed for dignity/respect. (Resident #D) The facility also failed to ensure a resident was not dressed in a institutional fashion for 1 of 7 residents observed for a dignified appearance. (Resident #H)	F000241	1.What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice? Allresidents have the potential to be affected by the deficient practice. For residentsD an investigation was completed regarding the incident. The investigation wasfound unsubstantiated. Employee #1	10/28/2014

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	Findings included: 1a. On 10/20/14 at 12:37 p.m., during an observation, Resident #D was heard asking a staff member for assistance. Employee #1 replied to Resident #D by saying "stop bugging people." Employee #1 had a stern tone of voice in his comment to Resident #D. On 10/21/14 at 11:38 a.m., during an interview, the Administrator indicated a staff member should never address a resident with the phrase "stop bugging people" He indicated such phrases and stern tones of voices are considered disrespectful and should not be used by staff members when speaking to facility residents. On 10/21/14 at 1:06 p.m., during an interview, Unit Manager #1 indicated no staff member should say "stop bugging people" to any resident as the Unit Manager indicated a statement like that would be a "demeaning" statement. She indicated facility residents should be spoken to "respectfully" and such a statement was a "disrespectful" statement. 1b. During an interview with Visitor #2, on 10/20/14 at 12:10 p.m., Visitor #2		was educated on dignity. Resident H is notinterviewable due to cognitive deficits. Resident H's responsible party/familywill be contacted regarding preferences. Care plans were updated accordingly. 2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveactions will be taken? All residents have the potential to be affected by thedeficient practice. An audit was done onall residents and interviewed regarding resident dressing preferences. No otherresident was affected by the deficient practice. 3.What measures will be put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur? The DON/Designee in-serviced all staff on dignity. An audit for dignitypreferences will be completed five days per week for four weeks, then threedays per week for four weeks, then once a week for four months or until 100%compliant. All new admissions will have preferences addressed. All care planswill be monitored with IDT members quarterly, including a review of care plan dresspreferences. Preferences will be updated on C.N.A. assignment sheets as changesare made. 4.How will the corrective actions be monitored toensure the	

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	indicated they observed/heard Employee #1 speak to Resident #D in a disrespectful tone, "hollering" at Resident #D, while Resident #D was asking for a beverage. Visitor #2 indicated he observed this while he was waiting in the facility lobby on 9/24/14. A Behavior Care Plan for Resident #D, dated 8/8/14, indicated an intervention to approach/speak in a calm manner. A Behavior Care Plan with the specific behavior listed above, dated 10/20/14, indicated an intervention to approach/speak in a calm manner. A Cognitive Loss Care Plan, dated 8/8/14, indicated an intervention to "promote dignity...." The Quarterly MDS (Minimum Data Set) assessment, dated 8/8/14, indicated Resident #D had a BIMS (Brief Interview of Mental Status) of 5, which was indicative of severe cognitive impairment. 2. The clinical record for Resident #H was reviewed on 10/21/14 at 11:00 a.m. The diagnoses for Resident #H included, but were not limited to, contractures and neurological deficits. The 8/30/14 Quarterly MDS (minimum data set) assessment for Resident #H		deficient practice will not recur; what quality assurance programwill be put into place? The DON/Designee will bring audit results to themonthly QA meeting for review and tracking and trending for 6 months or until95% compliant.	

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	indicated a brief interview for mental status was not conducted due to the resident being rarely/never understood. It indicated his functional status for dressing was total dependence of one person. An observation of Resident #H was made on10/21/14, at 11:46 a.m. He was lying in bed with a gown on. An interview was conducted with LPN #5 on 10/21/14, at 11:50 a.m., regarding Resident #H wearing a gown. She indicated, "He wears clothes sometimes." An interview was conducted with QMA #6 on 10/21/14 at 12:04 p.m., regarding whether she assisted Resident #H with getting dressed for the day. She indicated, "I got here at 6:00 a.m. He hasn't been out of bed today. He stays in his gown, if he's in bed. I didn't get him up today, because no one told me to get him up. When I got here, the nurse told me who to get up for breakfast, and he wasn't one of them." An interview was conducted with the DON (Director of Nursing) on 10/21/14 at 12:13 p.m., regarding her expectation for ensuring a resident, who needs assistance with dressing, gets dressed for the day. She indicated, "He should have clothes on. When (name of QMA #6) got			

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	him dressed this morning, she could have put clothes on him." Another observation of Resident #H was made with the DON at this time. He was still in a gown. During review of Resident #H's care plans, no care plan, regarding a preference for wearing a gown during the day, was found. On 10/21/14, at 1:30 p.m., the Nurse Consultant indicated Resident #H had no specific ADL (activities of daily living) care plan, and provided a copy of another care plan. It indicated Resident #H had limited physical mobility related to neurological deficits and contractures, with an intervention to provide supportive care and assistance with mobility, as needed. 3.1-3(t)			