STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00406374, IN00407853, and IN00410707. Complaint IN00406374 - No deficiencies related to the allegations are cited. Complaint IN00407853 - No deficiencies related to the allegations are cited. Complaint IN00410707 - Federal/state deficiencies related to the allegations are cited at F686 and F695. Survey dates: June 19 and 20, 2023 Facility number: 000171 Provider number: 155271 AIM number: 100267050 Census Bed Type: SNF/NF: 43 SNF: 14 Total: 57 Census Payor Type: Medicare: 3 Medicaid: 43 Other: 11 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 20, 2023	F 0000	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility is respectfully requesting a desk review for all deficiencies in the Plan of Correction.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chris Peter	Administrator	07/10/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure a resident who was identified with a pressure ulcer received timely treatment and continued treatment for 2 of 3 residents reviewed for pressure ulcers. (Resident B and Resident G) Findings include: 1. The clinical record for Resident B was reviewed on 6/19/23 at 12:00 p.m. The diagnoses included, but was not limited to, quadriplegia, anxiety disorder, burns involving 30-39% of body surface, tracheostomy status, and weakness. An admission assessment, dated 5/18/23, did not indicate any pressure ulcer concerns to Resident B's buttocks, sacrum, and/or coccyx area. There were third degree burns that were noted throughout Resident B's body surface area. A care plan for wounds, dated 5/19/23 and revised	F 0686	F686 Treatment/SVCS to Prevent /Heal Pressure Ulcer What corrective action will be accomplished for those residents found to have been affected by the deficient practice: It is the policy of the facility to ensure that all residents who are identified with a pressure ulcer receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Resident B no longer resides in the facility. All residents with wounds, including Resident G, were reviewed and verified treatment orders were in place. Completed June 20, 2023	07/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	on 6/15/23, indicated the following, "...I was admitted with pressure injury: Right gluteal fold. surgical wound to my left foot requiring use of wound vac to promote wound healing...BURNS INVOLVING 30-39% OF BODY SURFACE...Interventions...Administer treatment (product specific) as ordered...." A Weekly Wound Evaluation, dated 5/30/23, indicated a stage 2 pressure ulcer was identified on 5/27/23 to Resident B's right gluteal fold. The area measured 3.5 x 3.2 centimeters and was 0.2 centimeters in depth. The area contained 20% slough tissue with yellow wound color. The comments were to cleanse with wound cleanser, apply calcium alginate, and cover with a foam dressing. There were no progress notes, dated 5/27/23, in regards to any skin impairment identified to Resident B. A physician order, dated 5/31/23 for a start date of 6/1/23, to cleanse right gluteal fold with wound cleanser, apply calcium alginate, and cover with foam dressing daily. The electronic treatment administration record (ETAR), for June of 2023, indicated the initial treatment on 6/1/23 was not signed off. It was documented as refused on 6/2/23 and initially signed off, as completed, on 6/3/23. The date(s) of 6/11/23, 6/16/23, and 6/17/23 were left blank. 2. The clinical record for Resident G was reviewed on 6/20/23 at 11:14 a.m. The diagnoses included, but were not limited to, streptococcal sepsis, pressure ulcer of sacral region, stage 4, weakness, osteomyelitis of multiple sites, paraplegia, and prediabetes.		How other residents having the potential to affected by the same deficient practice will be identified and what corrective action will be taken. All residents that currently reside in the facility and have wounds can be affected by the alleged deficient practice. An audit was completed by the DON and ADON on July 7, 2023, to ensure all residents with pressure ulcers have wound treatment orders, wound treatments were completed per the physician order and all pressure wounds were staged appropriately. A facility wide skin sweep was completed on 7/6/2023 and 7/7/2023 Any new pressure ulcers were reviewed with the physician to ensure wounds were staged appropriately and treatment orders in place. What measures will be put in place and systemic changes will be made to ensure that deficient practice does not recur: The DON or Designee will educate by in servicing all licensed nursing staff on July 6, 2023, through July 9, 2023 on identifying wounds on admission or during weekly skin assessments, obtaining treatment orders timely, documentations of treatment on Treatment Administration Record/Medication Administration Record, policies “S.W.A.T., “Preventative Skin Care” and “Physician Orders”.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	An admission assessment, dated 4/27/23, indicated the following skin concerns for Resident G: - Two stage 3 pressure ulcers to the right buttock, - Three stage 3 pressure ulcers to the right hip, - A stage 3 pressure ulcer to the coccyx, - A stage 3 pressure ulcer to the sacrum, & - A stage 3 pressure ulcer to the left thigh (rear). A progress note, dated 4/27/23 at 11:09 p.m., indicated Resident G was admitted to the facility that evening. He was noted with multiple wounds on his buttocks and hips. The pressure ulcers were measured and dressings applied per orders. A wound care plan, revised 5/4/23, indicated the following, " ...I [Resident G] was admitted with pressure injuries to right buttock, right thigh (Rear), left gluteal fold and sacrum ...Interventions ...Administer treatment (product specific) as ordered ...." A physician order, dated 5/1/23, indicated to cleanse the wounds to right hip "tracts" and "right sacral tracts" with saline and gauze, flush wounds with rubber tipped catheter and saline, pack wounds with a strip of AquaCell AG, cover with absorbent secondary dressing. A physician order, dated 5/1/23, indicated to cleanse the wounds to bilateral ischium and sacral wound with saline and gauze, apply dakins solution to dry packing strips and pack wound, and cover with absorbent secondary dressing. There were no previous physician orders for		Any staff that fails to comply with the points of the in service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place: New admissions, weekly skin assessments and weekly wound evaluations will be audited for alterations in skin integrity and treatment orders daily 5 days a week for 4 weeks, then 3 days a week for 2 months and then weekly for 3 months. TAR/MAR will be audited daily 5 days a week for 4 weeks and the 3 days a week for 2 months and then weekly for 3 months If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Any concerns will be addressed immediately. However, any patterns will be identified, and any needed Action Plans will be written by the QAPI committee. Any written Action Plan will be monitored by the DON/Designee weekly until resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Resident G's wounds prior to 5/1/23. The ETAR for May of 2023 indicated the treatments for Resident G's pressure ulcers were not signed off, as completed, on 5/1/23 and 5/2/23. The initial treatment was completed on 5/3/23. A policy titled "Preventative Skin Care", undated, was provided by the Interim Director of Nursing (IDON) on 6/19/23 at 3:15 p.m. The policy indicated the following, "...It is the intent of the facility that the facility provide skin care through careful washing, rinsing, and drying to keep residents clean, comfortable, well-groomed and free from pressure sores...." A policy titled "S.W.A.T. - Skin Weight Assessment Team", undated, was provided by the IDON on 6/20/23 at 12:20 p.m. The policy indicated the following, " ...Policy ...Further, that a resident who enters the facility with pressure ulcers receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing ...." A policy titled "Physician Orders", undated, was provided by the IDON on 6/20/23 at 12:20 p.m. The policy indicated the following, " ...It is the policy of the facility to follow the orders of the physician. At the time of admission the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission ...." This Federal tag relates to Complaint IN00410707. 3.1-40(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on interview and record review, the facility failed to implement follow up instructions to change a tracheostomy every 2 weeks for 1 of 2 residents reviewed for tracheostomy status. (Resident B) Findings include: The clinical record for Resident B was reviewed on 6/19/23 at 12:00 p.m. The diagnoses included, but were not limited to, anxiety disorder, burns involving 30-39% of body surface, tracheostomy status, and quadriplegia. Resident B was admitted to the facility on 5/18/23. A respiratory care plan, dated 5/21/23, indicated Resident B had a tracheostomy that was a Shiley size 6.0. The interventions were to perform tracheostomy care daily and as needed along with keeping an additional tracheostomy tube (same size as the resident's) at bedside for an emergency situation. An "After Visit Summary", dated 5/25/23, indicated the following, "...1. Needs trach [tracheostomy] changed every 2 weeks. Last	F 0695	F695 Respiratory/Tracheostomy Care and Suctioning What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident B no longer resides in the facility. It is the policy of the facility to ensure that all residents who require respiratory care including tracheostomy care and suctioning is provided per physicians' orders and follow up appointments to change tracheostomy are followed. Facility will ensure that tracheostomy change appointments are completed. How other residents having the potential to affected by the same deficient practice will be identified and what corrective action will be taken. Facility currently does not have any residents with tracheostomy residing in the	07/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	change 5/5/23 with 7.0 cuffed portex. Trach needs to stay in place until next surgery is completed...." Another "After Visit Summary", dated 6/1/23, indicated the following, "...1. Needs trach changed every 2 weeks. Last change 5/5/23 with 7.0 cuffed portex...." Another "After Visit Summary", dated 6/8/23, indicated the following, "...2. Needs trach changed every 2 weeks. Last change 5/5/23 with 7.0 cuffed portex...." The tracheostomy tube mentioned in Resident B's care plan did not match the type and size of the tracheostomy tube mentioned in the follow up visits with the Nurse Practitioner at the burn clinic on 5/25/23, 6/1/23, and 6/8/23. A physician order, dated 6/8/23, indicated to change the 7.0 cuffed portex tracheostomy every 2 weeks. There were no previous physician orders to change Resident B's tracheostomy prior to 6/8/23. An interview conducted with the Interim Director of Nursing (IDON), on 6/20/23 at 10:20 a.m., indicated a company comes out to conduct visits related to residents with a tracheostomy and she was reaching out for any notes/visits for Resident B. An interview conducted with the IDON, on 6/20/23 at 12:58 a.m., indicated the company that comes out to conduct visits regarding residents respiratory status has no record of seeing Resident B. A policy titled "Tracheostomy Care Guidelines",		facility. What measures will be put in place and systemic changes will be made to ensure that deficient practice does not recur: The DON or Designee will educate by in servicing all licensed nursing staff on tracheostomy care guidelines, following physician orders, and scheduling tracheostomy change appointments. Education was completed on June 29, 2023. Any nurse that fails to comply with the points of the in service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place: Tracheostomy Care, scheduling follow up appointments related to tracheostomy change, and care plans matching order for tracheostomy size. will be completed daily, 5 days a week for 4 weeks, then 3 days a week for 2 months and then weekly for 3 months if the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Any concerns will be addressed immediately. However, any patterns will be identified, and any needed Action Plans will be written by the QAPI committee. Any written Action Plan will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	undated, was provided by the IDON on 6/19/23 at 3:15 p.m. The policy indicated the following, "...III. Procedure...a. Evaluation...4) Validate when tracheostomy care was last performed...b. Planning...1) Verify physician's order to provide tracheostomy care...d. Recording and reporting...1) Record respiratory evaluations before and after care; type and size of tracheostomy tube; frequency and extent of care; type, amount color, and odor of drainage; resident tolerance and understanding of procedure as applicable...." A policy titled "Physician Orders", undated, was provided by the IDON on 6/20/23 at 12:20 p.m. The policy indicated the following, " ...It is the policy of the facility to follow the orders of the physician. At the time of admission the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission ...." This Federal tag relates to Complaint IN00410707. 3.1-47(a)(4) 3.1-47(a)(6)		monitored by the DON/Designee weekly until resolved. Any concerns will be addressed immediately. However, any patterns will be identified, and any needed Action Plans will be written by the QAPI committee. Any written Action Plan will be monitored by the DON/Designee weekly until resolved.	