STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/19/2021

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00364849. Complaint IN00364849 - Substantiated. Federal/state deficiencies related to the allegations are cited at F677, F684, F689 and F790 Unrelated deficiencies are cited. Survey dates: October 18, and 19, 2021 Facility number: 000149 Provider number: 155245 AIM number: 100266840 Census Bed Type: SNF/NF: 39 Total: 39 Census Payor Type: Medicare: 8 Medicaid: 23 Other: 8 Total: 39 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 26, 2021	F 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by provisions of federal and state law. Castleton Health Care maintains that the alleged deficiencies do not individually or collectively jeopardize the health and /or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Castleton Health Care asserts that it is in substantial Compliance with governing the operation of long-term care facilities,	

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

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			and this Plan of Correction in its entirely constitutes this provider's credible allegation of compliance. **We respectfully request desk review (paper compliance) for compliance, if acceptable. Should additional information Be required to complete the request please advise.**	
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within			

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	5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report an allegation of verbal abuse for 1 of 5 residents reviewed. (Resident B) Findings include: The clinical record for Resident B was reviewed on 10/18/20 at 12:30 p.m. The resident's diagnoses included, but were not limited to, hemplegia following a stroke affecting left nondominant sides and need for assistance with personal care. An Admission MDS(Minimum Data Set) Assessment dated 9/12/21 indicated Resident B was cognitively intact. An interview was conducted with Resident B on 10/19/21 at 8:46 p.m. He indicated he was upset about how he had been treated by Qualified Medication Aide (QMA) 1 a week or two ago. He had requested a suppository that was for his bladder spasms, and she stated to him, "I am not putting anything up your a**." He had reported what was said to him to Nurse Practitioner (NP) 2 when she had came in for a visit. NP 2 had explained the suppository was no longer available, because of a shortage. An interview was conducted with NP 2 on 10/19/21 at 10:02 a.m. She indicated during a visit Resident B had reported to her that he had requested for his suppository by a QMA, and that staff person stated to him, "I am not putting anything up your a**." After she left the resident's room she had reported what was said to Resident B to the Assisted Director of Nursing (ADON) that day. She wanted to make sure the	F 0609	**F609 It is the policy of Castleton Health Care Center to follow the State and Federal Guidelines for Abuse and Reporting. Facility respectfully requests a desk review for F609.** **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. Executive director immediately suspended ADON and CNA pending allegation. b. Resident B was interviewed by Executive Director and statement obtained. Resident B showed no signs/symptoms of mental anguish during interview. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** a. All residents have the potential to be affected by this deficient practice. SSD interviewed A/O residents on 10/19/2021 – 10/20/2021 and no concerns were voiced. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. Staff was In-service by acting DON and Executive	11/15/2021

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	ADON was aware what had happened between the QMA and the resident. An interview was conducted with the Executive Director on 10/19/21 at 10:15 a.m. She indicated no one had reported anything to her regarding QMA 1 and Resident B. The statement that was made was reportable, and she would be reporting it to Indiana Department of Health. An Abuse policy was provided by the Director of Nursing on 10/19/21 at 4:53 p.m. It indicated "...Policy: Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property, collectively known and referred to as ANEMM and as hereafter defined, will not be tolerated by anyone including staff, patients, volunteers, family members or legal guardians, friends or any other individuals. The Health Center Administrator is responsible for assuring that Patients' Rights of personal privacy, confidentiality and dignity will be respected for all aspects of care an services and that patient safety, including freedom from risk of ANEMM, holds the highest priority...III. Prevention Issues: Policy:...All supervisory staff will identify inappropriate behaviors, including but not limited to the use of derogatory language...and will take immediate steps to correct such behaviors...IV....Any patient event that is reported to any staff by patient, family, other staff or any other person will be considered as possible ANEM if if meets any of the following criteria: ...e. Any complaint of the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to patients or families or within their hearing distance...Procedure: Any and all staff observing or hearing about such events must report the event immediately to the Administrator, Immediate		Director on Abuse was initiated on 10/19/2021 and 11/9/2021. Inservice will continue for any new staff hired. b. SSD/Designee will complete random resident interviews weekly x 8, then weekly x 4, then weekly x 2. **4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** Findings of random resident interviews will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined	

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	Supervisor and one of the following: Director of Nursing, ANEM Prevention Coordinator, or Risk Manager, so that appropriate reporting and investigating procedures take place immediately...VI. Protection issues:...Patients will be protected from harm during an investigation...Staff person or persons suspected of ANEM will be suspended immediately pending result of the investigation...VII: Reporting and response issues:...It will also be reported to other officials, in accordance with State and Federal Regulations..." 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview and record review, the facility failed to ensure a resident's safety was maintained after an allegation of abuse was reported for 1 of 5 residents reviewed.	F 0610	**F610 It is the policy of Castleton Health Care Center to follow the State and Federal Guidelines for Abuse and**	11/15/2021

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	(Resident B) Findings include: The clinical record for Resident B was reviewed on 10/18/20 at 12:30 p.m. The resident's diagnoses included, but were not limited to, hemplegia following a stroke affecting left nondominant sides and need for assistance with personal care. An Admission MDS(Minimum Data Set) Assessment dated 9/12/21 indicated Resident B was cognitively intact. An interview was conducted with Resident B on 10/19/21 at 8:46 p.m. He indicated he was upset about how he had been treated by Qualified Medication Aide (QMA) 1 a week or two ago. He had requested a suppository that was for his bladder spasms, and she stated to him, "I am not putting anything up your a**." He had reported what was said to him to Nurse Practitioner (NP) 2 when she had came in for a visit. An observation was made of Resident B on 10/19/21 at 8:55 a.m. Qualified Medication Aide (QMA) 1 was observed delivering a breakfast tray into Resident B's room. After, she left the room and returned back to his room with items for his coffee. During that time, Resident B was observed lying in his bed. After QMA 1 had left the resident's room, Resident B had confirmed QMA 1 was the staff person that had made the statement to him. An interview was conducted with NP 2 on 10/19/21 at 10:02 a.m. She indicated during a visit Resident B had reported to her that he had requested for his suppository by a QMA, and that staff person stated to him, "I am not putting		**Reporting. Facility respectfully requests a desk review for F610** **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. Executive director immediately suspended ADON and CNA pending allegation. Executive director immediately reported allegation upon notification by surveyor. b. Resident B was interviewed by Executive Director and statement obtained. Resident B showed no signs/symptoms of mental anguish during interview. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** a. All residents have the potential to be affected by this deficient practice. SSD interviewed A/O residents on 10/19/2021-10/20/2021 and no concerns were voiced. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. Staff was in-service by acting DON and Executive Director on Abuse was initiated on 10/19/2021 and 11/9/21. Inservice consisted of types of abuse, abuse policy, who the abuse coordinator is, and to report any	

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	anything up your a**." After she left the resident's room she had reported what was said to Resident B to the Assisted Director of Nursing (ADON) that day. She wanted to make sure the ADON was aware what had happened between the QMA and the resident. An interview was conducted with the Executive Director (ED) on 10/19/21 at 10:15 a.m. She indicated no one had reported anything to her regarding QMA 1 and Resident B. The statement that was made was reportable, and she would be reporting it to Indiana Department of Health. She would immediately suspend QMA 1 and start an investigation. An Abuse policy was provided by the Director of Nursing on 10/19/21 at 4:53 p.m. It indicated "...Policy: Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property, collectively known and referred to as ANEMM and as hereafter defined, will not be tolerated by anyone including staff, patients, volunteers, family members or legal guardians, friends or any other individuals. The Health Center Administrator is responsible for assuring that Patients' Rights of personal privacy, confidentiality and dignity will be respected for all aspects of care an services and that patient safety, including freedom from risk of ANEMM, holds the highest priority...III. Prevention Issues: Policy:...All supervisory staff will identify inappropriate behaviors, including but not limited to the use of derogatory language...and will take immediate steps to correct such behaviors...IV....Any patient event that is reported to any staff by patient, family, other staff or any other person will be considered as possible ANEM if if meets any of the following criteria: ...e. Any complaint of the use of oral, written or		alleged abuse to the ED immediately. Inservice will continue for any new staff hired. a. Executive Director/DON will report any alleged allegation of abuse per State and Federal Guidelines and facility will follow the abuse facility policy on reporting per State and Federal Guidelines. b. SSD/Designee will complete random resident interviews weekly x 8, then weekly x 4, then weekly x 2 and will report any findings of alleged abuse to the Executive Director or DON. **1. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. Findings of random resident interviews will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined. **2. DOC: 11/15/21**	

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	gestured language that willfully includes disparaging and derogatory terms to patients or families or within their hearing distance...Procedure: Any and all staff observing or hearing about such events must report the event immediately to the Administrator, Immediate Supervisor and one of the following: Director of Nursing, ANEM Prevention Coordinator, or Risk Manager, so that appropriate reporting and investigating procedures take place immediately...VI. Protection issues:...Patients will be protected from harm during an investigation...Staff person or persons suspected of ANEM will be suspended immediately pending result of the investigation...VII: Reporting and response issues:...It will also be reported to other officials, in accordance with State and Federal Regulations..." 3.1-28(d)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to ensure showers and shaving were provided for 2 of 3 residents reviewed for Activities of Daily Living (ADLS). (Resident C and D) Findings include: 1. The clinical record for Resident D was reviewed on 10/18/20 at 12:30 p.m. The resident's diagnoses included, but were not limited to, dementia with lewy bodies and Parkinson's Disease. Resident D	F 0677	**F677 It is the policy of Castleton Health Care to ensure residents ADLs are provided to all residents requiring assistance. Facility respectfully requests a desk review for F 677.** **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**	11/15/2021

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	was admitted to the facility on 10/1/21. An Admission MDS(Minimum Data Set) Assessment dated 10/14/21 indicated Resident D was total dependant of 1 person for bathing. A care plan for ADLs dated 10/1/21 indicated "The resident [D] has an ADL self-care performance deficit r/t [related to] parkinsons...AM routine: The residents preferred dressing/grooming routine is in the a.m. and as needed..." An Aide Care Plan Worksheet was provided on 10/18/21 at 12:20 p.m. It indicated Resident D received showers Mondays and Thursday on day shift. An observation was made of Resident D on 10/18/21 at 12:50 p.m. Resident D was observed sitting in his wheelchair and was observed with gray facial hair on his face and neck. An interview was conducted with Family Member 13 on 10/18/21 at 12:55 p.m. She indicated Resident D had only been shaved once since he was admitted on 10/1/21. She would like for the staff to shave him more. An observation was made of Resident D on 10/19/21 at 12:40 p.m. Resident D was observed to have facial hair his face and neck. An interview was conducted with Certified Nursing Assistant (CNA) 2 and CNA 3 on 10/19/21 at 11:25 a.m. They indicated the residents should be shaved on shower days, as needed, or requested. Some residents want to be shaved during the shower and others request for the shaving after shower.		a. Resident D was shaved and has discharged from facility. (10/26/21) b. Resident C received shower per her request on 10/20/2021. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** a. All residents have the potential to be affected by the same deficient practice. Shower schedule updated with shaving added. Shower preferences completed by acting DON / Designee completed on 11/2/2021. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** **a.** Nursing staff in-service on shaving/showers and changes to be completed on 11/9/2021 and new staff educated upon hire. b. Shower schedule updated with shaving added. CNA assignment sheet updated with showers. c. DON/designee will review shower sheets 5 x a week for 8 weeks, then 3 x a week for 4 weeks, then weekly. **4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. Findings will be reported monthly at the QA/Risk	

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	An interview was conducted with CNA 4 on 10/19/21 at 12:55 p.m. She indicated residents should be shaved on shower days or as needed. She was not sure why Resident D had not been shaved. A shower sheet for Resident D dated 10/18/21 was provided by the Director of Nursing on 10/19/21 at 5:34 p.m. It indicated Resident D was provided a shower on 10/18/21. 2. The clinical record for Resident C was reviewed on 10/18/20 at 12:00 p.m. The resident's diagnoses included, but were not limited to, stroke, Chronic Obstructive Pulmonary Disease (COPD), and difficulty walking. A Quarterly 7/21/21 MDS (Minimum Data Set) assessment indicated Resident C was cognitively intact. She required physical help with 1 staff person for bathing. A care plan dated 4/14/21 indicated "The resident has an ADL self-care performance deficit r/t [related to] h/o [history of] cva [stroke] with residual deficit impaired mobility and balance...bathing/showering: The resident requires ext [extensive] assistance by (x1) [times 1] staff with bathing/showering as necessary.." An Aide Care Plan Worksheet was provided on 10/18/21 at 12:20 p.m. It indicated Resident C received showers Wednesdays and Saturdays evenings. The following days and dates Resident C had received or not received showers: Wednesday - 9/1/21, Sunday - 9/5/21, Wednesday - 9/8/21,		management meeting until such time substantial compliance has been determined. **5. DOC: 11/15/21**	

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	Saturday - 9/11/21, Wednesday - 9/15/21 - refused, Saturday - 9/18/21, Wednesday - 9/22/21, Saturday 9/25/21, - no shower sheet provided, Wednesday - 9/29/21 - no shower sheet provided, Saturday - 10/2/21 - no shower sheet provided, Wednesday - 10/6/21, Saturday - 10/9/21, Wednesday - 10/13/21, and Saturday - 10/16/21 - no shower sheet provided An interview was conducted with Resident C on 10/18/21 at 12:35 p.m. She indicated she was suppose to receive showers twice a week in the evenings. She receives only one shower a week on Wednesday evenings. She would prefer to get more than one, but its a "hassle" just to get one around here. "Sometimes I don't even get one." An interview was conducted with CNA 4 on 10/19/21 at 12:55 p.m. She indicated the scheduled shower days are on the aide work sheets. She had no problem with getting the scheduled showers completed on her shift. After a resident's shower was completed the CNA that provided the shower fills out the shower sheet and documents the completion. An Activities of Daily Living (ADLS) policy was provided by the Executive Director on 10/18/21 at 10:32 a.m. It indicated "...Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLS). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and oral hygiene...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and			

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	assistance with a. hygiene (bathing, dressing, grooming, and oral care);..." A "Bath, Shower/Tub" policy was provided by the Executive Director on 10/18/21 at 10:32 a.m. It indicated "...The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin...Documentation 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath. 3. All assessment data (e.g. any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. 4. How the resident tolerated the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s), why and the intervention taken. 6 The signature and title of the person recording the data..." This Federal tag relates to complaint IN00364849. 3.1-38(a)(3)(D)(B)(2)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a urologist appointment was made timely for 1 of 3 residents reviewed for outside appointments. (Resident B)	F 0684	**F684 It is the policy of Castleton Health Care to ensure residents appointments are made timely for**	11/15/2021

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	Findings include: The clinical record for Resident B was reviewed on 10/18/20 at 12:30 p.m. The resident's diagnoses included, but were not limited to, hemplegia following a stroke affecting left nondominant sides and need for assistance with personal care. Resident B was admitted to the facility on 9/8/21. An Admission MDS(Minimum Data Set) Assessment dated 9/12/21 indicated Resident B was cognitively intact. A physician order for Resident B dated 9/10/21 indicated the staff was to make a urology appointment for stent removal. A physician note dated 9/24/21 indicated Nurse Practitioner 2 had discussed with the Director of Nursing (DON) a follow up appointment was needed to be made for the removal of his stent. A late entry progress note created on 10/5/21 written by the Assistant Director of Nursing (ADON) indicated on 9/13/21, she had contacted the urology office to make an appointment for Resident B's stent removal. A late entry progress note created on 10/5/21 written by the ADON indicated on 9/21/21, she had spoken to the urologist nurse to set up the appointment for Resident B's stent removal. The urologist nurse would call her back to schedule. A progress note dated 10/5/21 written by the ADON indicating she had left a message for the urologist office to schedule an appointment for Resident B's stent removal.		**appointments. Facility respectfully requests a desk review for F684** **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. Resident B was seen by urology on 10/20/2021. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** a. All residents have the potential to be affected by the same deficient practice. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** **a.** Nursing in-service to be completed on 11/9/2021 on physician appointments, charting of appointment time, date and person of who was spoken to. b. Appointments will be reviewed daily in clinical meeting. c. DON/Designee will do random appointment audits 3 times weekly for 8 weeks, then 2 times a week for 4 weeks, then weekly. **4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. Findings will be reported monthly at the QA/Risk	

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	A physician note dated 10/8/21 indicated Resident B's would be going to the urology office for stent removal on 10/20/21. There was no documentation in the clinical record the DON had contacted the urologist office to schedule the appointment nor was there documenation when the appointment was scheduled for 10/20/21. During a confidential interview on 10/18/21 at 10:29 a.m., she indicated Resident B had a urinary stent that needed to be removed, and the resident's appointment had not been made. An interview was conducted with Resident B on 10/19/21 at 8:46 a.m. He indicated he did have a urinary stent that was causing him pain that needed to be removed. There was a long delay in the staff making an appointment with his urologist for the removal. The staff did tell him it was scheduled now on 10/20/21 for his stent to be removed at the urologist's office. An interview was conducted with the ADON on 10/19/21 at 9:54 a.m. She indicated she had made several attempts to contact the urologist to schedule the removal of Resident B's stent. She finally was able to reach someone, and it was scheduled for 10/20/21. An interview was conducted with the Urologist Staff Person 3 on 10/19/21 at 3:58 p.m. She indicated it was difficult to schedule Resident B's stent removal. The urologist office had attempted to contact Resident B on 9/7/21 and received no call back from him to reschedule his missed appointments in June and September prior to his admission to the facility. The facility's DON had notified the urologist's office on 9/17/21 indicating		management meeting until such time substantial compliance has been determined. **5. DOC: 11/15/21**	

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	Resident B needed to be scheduled for a stent removal and left message for a return call. The Urologist office staff returned the DON's call, and was unable to reach the DON at that time. The office received another message from the DON on 9/28/21 requesting to schedule the appointment. The urologist staff returned the DON's call, and she was unable to be reached. The Urologist Staff Person 3 indicated the office had been returning the DON's calls, but each time the facility staff would report the DON was either in a meeting or unavailable. The messages that were left at their office were from the DON not the ADON. On 9/29/21, the urologist office staff contacted the facility and requested to speak with Resident B's nurse instead of the DON. At that time, the appointment was made with his nurse. He was scheduled for 10/20/21. This Federal tag relates to complaint IN00364849. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure neurological (neuro) assessments were conducted, falls were evaluated, interventions were implemented, and a resident was transferred with 2 staff members for 3	F 0689	**F689 It is the policy of Castleton Health Care to ensure neurological assessments are conducted, evaluate falls and review**	11/15/2021

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	of 3 residents reviewed for falls. (Resident B, C, D) Findings include: 1. The clinical record for Resident B was reviewed on 10/18/20 at 12:30 p.m. The resident's diagnoses included, but were not limited to, hemplegia following a stroke affecting left nondominant sides and need for assistance with personal care. Resident was admitted on 9/8/21. An Admission MDS(Minimum Data Set) Assessment dated 9/12/21 indicated Resident B was cognitively intact. The resident required extensive assistance with 2 persons for bed mobility, transfers, toileting and dressing. An Aide Care Plan Worksheet was provided by the Assistant Director of Nursing (ADON) on 10/18/21 at 12:20 p.m. It indicated Resident B was requiring 2 staff members to transfer him. A fall care plan for Resident B dated 9/13/21 indicated "The resident is at risk for falls r/t [related to] weakness, htn [hypertension] and impaired mobility, morbid obesity, enlarged heart...Interventions: ..Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. An ADL [Activities of Daily Living] care plan for Resident B dated 9/9/21 indicated "The resident has an ADL self-care performance deficit r/t history of cva [stroke] with left sided weakness...Interventions...Transfer: The resident requires extensive assistance by (x1) [times 1] staff to move between surfaces as necessary..." An incident report for Resident B dated 9/19/21 at 6:43 p.m., indicated "Resident was sitting at the		**interventions for falls. The facility respectfully requests a desk review for F689.** **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** 1. Resident D no longer resides at facility. 2. Resident B and C care plans update with new interventions of transfer status. 3. Going forward, neurological assessments to be completed per policy. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** 1. All residents have the potential to be affected by the same deficient practice. 2. DON/Designee completed audit of fall care plans for transfer status on 11/5/2021. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** **1.** Nursing staff in-service on fall assessment, neurological assessments, transfer status and interventions to be completed on 11/9/2021. 2. Falls will be reviewed in morning clinical meeting and neurological assessments will be	

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	bedside in his wheelchair and attempted to self transfer to the bed. Resident successfully transferred to the bed. D/T [due to] left left-sided weakness resident slid to the floor per resident. Resident denies injuries..." A "Post Fall Evaluation" dated 9/20/21 indicated Resident B had unwitnessed fall. He was found on the floor of his room. The summary indicated neuro checks would be conducted and education to the resident. A Neurological Record dated 9/19/21 at 3:30 p.m., indicated neuro checks were conducted as the following: 9/19/21 - no time documented on first check, 9/20/21 - 12:00 a.m., 9/20/21 - 4:00 a.m., 9/20/21 - 6:00 a.m., 9/20/21 - 6:00 a.m. - 2:00 p.m., 9/20/21 - 2:00 p.m., - 10:00 p.m., 9/20/21 - 10:00 p.m., - 6:00 a.m., 9/21/21 - 6:00 a.m., - 2:00 p.m., 9/21/21 - 2:00 p.m., - 10:00 p.m., and 9/21/21 - 10:00 p.m., - 6:00 a.m., An interview was conducted with Resident B on 10/19/21 at 8:46 p.m. He indicated he had fallen 3 times since admission on 9/8/21. The first fall occurred about a month ago. He was sitting in his wheelchair and scooted himself to the edge to transfer himself from wheelchair to the recliner. As he was scooting himself to the edge of the wheelchair he had slid off the wheelchair to the ground. The 2nd fall occurred with the therapist. He had been transferring from wheelchair to recliner in his room, and he lost his balance. He landed on the floor and another staff person came in to help the therapist get him up off the floor. The 3rd fall occurred with License Practical Nurse		reviewed for compliance and interventions will be initiated at IDT review. **4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** 1. Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined. **5. DOC: 11/15/21**	

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	(LPN) 5 during a transfer from wheelchair to recliner. He fell to the floor, and staff came in to assist LPN 5 to help him off the floor. Resident B's medical record did not have documented incidents noted regarding the resident's falls with the therapist nor LPN 5. An interview was conducted with the Director of Therapy on 10/19/21 at 10:20 a.m. She indicated Resident B had fallen during a transfer with her in his room. The resident was transferring from wheelchair to recliner. As he stood up with the hemi-walker he lost his balance and fell on the floor. The resident had not hit his head and denied pain at that time. She immediately went and had gotten LPN 6 to assess the resident. An Occupational Therapy note dated 9/23/21 was provided by the Director of Therapy. It indicated "...Pt [patient] trained in standing balance and weight shifting exercises to increase ability to safely stand and support self through (L) [left] LE [lower extremities] during ADLS and transfers...Pt attempted w/c [wheelchair] to recliner transfer with hemi-walker, demonstrated impulsivity and poor response to instruction on use of hemi-walker and LOB [loss of balance] anteriorly and fell and therapist unable to correct LOB. attempted to lower to floor and avoid hitting head. Nursing staff notified of fall and performed assessment and transferred from floor.." An interview was conducted with LPN 5 on 10/19/21 at 11:32 a.m. He indicated Resident B had fallen the following day after the resident had fallen with the therapist. LPN 5 was transferring the resident from recliner to wheelchair by himself. The resident had reached the wheelchair but was not sitting all the way back and slid to the floor.			

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	LPN 5 had transferred Resident B without other staff assistance before, and it was successful. He did not document the fall, because it was witnessed. The resident was not injured. An interview was conducted with Certified Nursing Assistant (CNA) 4 on 10/19/21 at 12:55 p.m. She indicated Resident B was to be transferred with 2 staff members per the aide worksheet. 2. The clinical record for Resident C was reviewed on 10/18/20 at 12:00 p.m. The resident's diagnoses included, but were not limited to, stroke, Chronic Obstructive Pulmonary Disease (COPD), and difficulty walking. A Quarterly 7/21/21 MDS (Minimum Data Set) assessment indicated Resident C was cognitively intact. She required extensive assistance with 1 staff person for transfers. A fall care plan for Resident C dated 6/29/21 indicated "The resident is risk for falls r/t gait/balance problems, impaired functional mobility, seizers, impulse disorder...Interventions:..mat at bedside while resident in bed. An Aide Care Plan Worksheet was provided by the Assistant Director of Nursing (ADON) on 10/18/21 at 12:20 p.m. It indicated Resident C was stand by assistance for transfers. An incident note dated 8/27/21 indicated Resident C had an unwitnessed fall in her room. She was found sitting on the floor next to her low bed. An IDT note dated 9/1/21 indicated Resident C had an unwitnessed fall that occurred on 8/31/21.			

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	Resident C was ambulating without assistance. "...will continue current interventions and plan of care..." An IDT note dated 9/6/21 indicated Resident C had an unwitnessed fall that occurred on 9/4/21. Resident C had lost her balance adjusting her heater while in her room. "...resident has unsteady gait at baseline...Will continue current interventions and plan of care.." A nursing note dated 9/25/21 indicated the resident had unwitnessed fall. She was found on the floor. An incident note dated 9/29/21 indicated the resident had unwitnessed fall. She was on the floor. She stated she had slipped off the low bed. An incident note dated 10/3/21 indicated the resident had unwitnessed fall. The resident was found on the floor on her right side. An incident note dated 10/17/21 indicated Resident C had unwitnessed fall. The resident had slipped off the bed in a sitting position. The nurse assisted resident to bathroom. The resident fell to the right side with loss of her balance. The staff nurse attempted to break her fall. A post fall assessment dated 9/25/21 indicated "...Findings/Summary: Recommendations:...non-slip footwear...identify items residents wants to wear...resident education..." There was no other post fall assessments provided for the falls on 8/27/21, 9/1/21, 9/6/21, 9/29/21, 10/3/21 and 10/17/21.			

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	The Neurological Record dated 9/29/21 indicated the following neuro checks conducted for Resident C: 9/29/21 - 1:30 a.m., 9/29/21 - 1:45 a.m., 9/29/21 - 2:00 a.m., 9/29/21 - 2:15 a.m., 9/29/21 - 3:30 a.m., 9/29/21 - 5:00 a.m., and 9/30/21 - 10-6 (no time of the day) The Neurological Record dated 10/3/21 indicated the following neuro checks conducted for Resident C: 10/3/21 - 4:45 a.m., 10/3/21 - 5:00 a.m., 10/3/21 - 5:15 a.m., 10/3/21 - 5:30 a.m., 10/3/21 - 6:00 a.m., 10/3/21 - evenings, 10/3/21 - nights, and 10/421 - nights The Neurological Record dated 10/13/21 indicated the following neuro checks conducted for Resident C: 10/13/21 - 6:45 a.m., 10/13/21 - 12:00 p.m., 10/13/21 - 8:00 p.m., 10/14/21 - 5:00 a.m., 10/14/21 - 9:00 a.m., 10/14/21 - 5:00 p.m., and 10/15/21 - 3:00 a.m., There were no other neurological records provided. An observation was made of Resident C on 10/18/21 at 12:35 p.m. The resident's door was closed at that time. Resident C was observed lying			

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	in bed. There was no mat at bedside observed. An interview was conducted with Resident C. She indicated she does not use any assistance devices when she ambulates. She does get dizzy at times which causes her to fall. An observation was made of Resident C on 10/19/21 at 11:25 a.m. Resident C was observed lying in bed. A blue mat was up against the wall in the bathroom. Resident C indicated at that time, the staff use to place the mat by her bed at night. They don't do that anymore. 3. The clinical record for Resident D was reviewed on 10/18/20 at 12:30 p.m. The resident's diagnoses included, but were not limited to, dementia with lewy bodies and Parkinson's Disease. Resident D was admitted to the facility on 10/1/21. An Admission MDS(Minimum Data Set) Assessment dated 10/14/21 indicated Resident D was total dependant of 1 person for bathing and extensive assistance with 1 staff person with toileting. A fall care plan for Resident D dated 10/5/21 indicated "The resident is (sic) for falls...Interventions:...Review information on past falls and attempt to determine cause of falls. Record possible root cause..." An IDT note dated 10/4/21 indicated Resident D had unwitnessed fall that occurred on 10/3/21. The resident was looking for the bathroom. Interventions that were put in place at that time was staff to take resident to the restroom at night. An IDT note dated 10/8/21 indicated Resident D had unwitnessed fall that occurred on 10/7/21. The resident indicated he was taken self to the			

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	bathroom without assistance. Interventions that were put in place at that time was to take the resident to the bathroom at night. A post fall evaluation dated 10/16/21 indicated the resident was lowered to the floor by staff member. The Neurological Record dated 10/3/21 indicated the following neuro checks conducted for Resident D: 10/3/21 - 1:00 a.m., 10/3/21 - 1:15 a.m., 10/3/21 - 1:30 a.m., 10/3/21 - 1:45 a.m., 10/3/21 - 2:15 a.m., 10/3/21 - 2:45 a.m., 10/3/21 - 3:45 a.m., 10/3/21 - 4:45 a.m., and 10/3/21 - 5:45 a.m., The Neurological Record dated 10/4/21 indicated the following neuro checks conducted for Resident D: 10/4/21 - 9:30 a.m., 10/4/21 - 9:45 a.m., 10/4/21 - 10:00 a.m., 10/4/21 - 10:15 a.m., 10/4/21 - 10:45 a.m., 10/4/21 - 11:15 a.m., 10/4/21 - 11:45 a.m., 10/4/21 - 12:15 p.m., 10/4/21 - 1:15 p.m., 10/4/21 - 2:15 p.m., 10/4/21 - 3:15 p.m., 10/4/21 - 4:15 p.m., 10/4/21 - 10-6 p.m., and 10/5/21 - 6: 00 a.m.,-2:00 p.m. shift, The Neurological Record dated 10/7/21 indicated the following neuro checks for Resident D:			

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	10/7/21 - 1:00 a.m., 10/7/21 - 1:15 a.m., 10/7/21 - 1:30 a.m., 10/7/21 - 1:45 a.m., 10/7/21 - 2:00 a.m., 10/7/21 - 2:30 a.m., 10/7/21 - 3:00 a.m., 10/7/21 - 3:30 a.m., 10/7/21 - 4:00 a.m., 10/7/21 - 4:30 a.m., 10/7/21 - 5:30 a.m., 10/7/21 - 6:30 a.m., 10/7/21 - 7:30 a.m., 10/7/21 - 8:30 a.m., and 10/7/21 - 2:00 p.m., - 10:00 p.m. shift There was no other neurological assessments provided. An interview was conducted with the Director of Nursing on 10/19/21 at 2:45 p.m. The staff are required to document when a resident has had a fall. The IDT then evaluates and places interventions for fall precautions. The care plans at that time would be updated and should be followed. The staff don't always use the post evaluations assessments. The staff should be conducting neurological assessments for 72 hours after a resident has had unwitnessed fall or has hit his or her head. She was unaware Resident B had a fall with LPN 5, and a fall with the therapy department. A Neurochecks post-fall document was provided by the Director of Nursing on 10/18/21 at 9:44 a.m. It indicated "All neurochecks to be completed as follows: every 15 minutes x 1 hour, Every 30 minutes x 2 hours, Every 1 hour x 4 hours, Every 8 hours x 72 hours."			

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	155245	A. BUILDING 00 B. WING	10/19/2021

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	A Neurological Assessment policy was provided by the Director of Nursing on 10/18/21 at 3:18 p.m. It indicated "...The purpose of this procedure is to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall...General Guidelines 1. Neurological assessments are indicated: a. Following an unwitnessed fall;.." A Falls and Fall Risk policy was provided by the Executive Director on 10/18/21 at 10:32 a.m. It indicated "...Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling...Resident-Centered Approaches to Managing Falls and Fall Risk...5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant...Monitoring Subsequent Falls and Fall Risk...1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the intervention or reconsider whether the measures are still needed if a problem that required the intervention..has resolved. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions..." This Federal tag relates to complaint IN00364849. 3.1-45(a)			

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F 0790 SS=D Bldg. 00	483.55(a)(1)-(5) Routine/Emergency Dental Srvcs in SNFs §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the			

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	extenuating circumstances that led to the delay. Based on interview and record review, the facility failed to follow up on a dental appointment for a resident that was having tooth pain for 1 of 3 residents reviewed for outside appointments. (Resident B) Findings include: The clinical record for Resident B was reviewed on 10/18/20 at 12:30 p.m. The resident's diagnoses included, but were not limited to, hemplegia following a stroke affecting left nondominant sides and need for assistance with personal care. Resident B was admitted to the facility on 9/8/21. An Admission MDS (Minimum Data Set) Assessment dated 9/12/21 indicated Resident B was cognitively intact. A dental consent dated 9/16/21 indicated Resident B wanted to be provided with dental services. A care plan dated 9/9/21 indicated "The resident has an ADL [Activities Daily Living] self-care performance deficit r/t [related to] history of CVA [stroke] with left sided weakness...Interventions: oral care: The resident has own teeth Report changes/concerns to the Nurse..." A nursing progress note dated 9/29/21 at 1:42 p.m., indicated "Resident had had c/o [complaints] tooth pain upper back right side of jaw. Pain and tenderness with food and drink states 'even the air hurts.' Resident set up appointment with [name of dental office] and transport set to p/u [pick up] at 3pm (sic) today. A progress note dated 9/29/21 at 9:38 p.m.,	F 0790	**F790 It is the policy of Castleton Health Care to ensure residents receive Dental Services routinely and 24- hour emergency dental care. Facility respectfully requests a desk review for F 790** **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. Resident B scheduled dental appointment is on 11/4/2021. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** a. All residents have the potential to be affected by the same deficient practice. b. SSD/Designee will be setting up routine visits with Prevmed for dental services. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** **a.** Nursing in-service to be completed on 11/9/2021 on physician appointments, charting of appointment time, date and person of who was spoken to. b. Appointments will be reviewed daily in clinical meeting.	11/15/2021

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	indicated "Resident A/O [alert and oriented] x [times] 4. able to make needs known...Did not got (sic) to dentist and will go tmr (tomorrow). Face swollen and teeth react to cold water..." The clinical record did not include documentation the resident's dentist appointment had been rescheduled, what day he went out nor staff follow up after the dental appointment. An interview was conducted with Resident B on 10/19/21 at 8:46 a.m. He indicated he had a bad tooth that needed to be fixed on the right side. He made his own dental appointment, and the facility provided the transportation. There was a transportation problem, and he was unable to go that day. The appointment was rescheduled by the staff, and he was able to go a few days later. The dentist at the clinic indicated he was unable to treat, because he was on an anticoagulant. The appointment would need to be rescheduled after he received the doctor's approval. He hadn't heard anything from the staff, and the dentist appointment had not been rescheduled. Resident B indicated the tooth still hurt, and it needed to be fixed. An interview was conducted with the Social Services Director (SSD) on 10/19/21 at 10:00 a.m. She indicated she was new to the building. She was unaware of a dental appointment for Resident B that he had and was unable to be treated due to the medication he was on. An interview was conducted with the Director of Nursing on 10/19/21 at 4:53 p.m. She indicated the resident had made his own appointments to go to an outside dental office, but the facility had provided the transportation. She had contacted the resident's dental office today, and the office		c. SSD/Designee will track dental appointments to ensure resident receive dental services as needed. **4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined. **5. DOC: 11/15/21**	

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	indicated he was seen on 10/1/21. The dental office staff reported to the DON the resident was needing a medical clearance form filled out prior to proceeding with treatment. The medical release form was sent with the resident on 10/1/21. The DON indicated she had filled out the form, sent it back to the dental office and rescheduled the appointment. A Dental Services policy was provided by the Director of Nursing on 10/19/21 at 5:07 p.m. It indicated "Routine and as needed dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care...1. Routine and as needed dental services are provided to our residents through..referral to the resident's personal dentist;..4. Social services representatives will assist residents with appointments, transportation arrangements...9. All dental services provided are recorded in the resident's medical record..." This Federal tag relates to complaint IN00364849. 3.1-24(a)			