	WIEDICAKE & MEDIC				OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155271	B. WING	<del></del>	04/02/2025
		<u> </u>	CTDE	ET ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	₹		CLEARVISTA PL	
WATERS	S OF CASTLETON	SKILLED NURSING FACILITY,		ANAPOLIS, IN 46256	
VVAILING	- CONTINUE TO THE TOTAL TOTAL TO THE TOTAL TOTAL TO THE TOTAL TOTAL TOTAL TOTAL TO THE TOTAL TOT	CRILLED NOROING LACILITY,	11.12	- 147.11 OLIO, 114 70250	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROP	E COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000					
Bldg. 00					
			F 0000	Preparation and/or executio	
	This visit was for the Investigation of Complaints			this plan of correction in ger	•
	IN00450054, IN004	451947 and IN00456622.		or this corrective action does	s not
				constitute an admission of	[
		0054 Federal/state deficiencies		agreement by this facility of	
		ations are cited at F656 and		facts alleged or conclusions	set
	F677			forth in this statement of	
				deficiencies. The plan of cor	
	Complaint IN00451947 Federal/state deficiency related to the allegations is cited at F550.			and specific corrective actio	
				prepared and/or executed in	
	G 1			compliance with State and F	•
	_	6622 Federal/state deficiencies		Laws. Facility's date of alleg	
	I -	ations are cited at F580 and		compliance is April 25, 2025	
	F842.			Facility is respectfully reque	sting
	TT 1 . 1 1 0 '			paper compliance for all	
	Unrelated deficienc	ey is cited.		deficiencies in this POC.	
	Survey dates: Marc	ch 31, April 1 and 2, 2025			
	Burvey dates. Mark	51, April 1 and 2, 2023			
	Facility number: 0	00171			
	Provider number: 1				
	AIM number: 1002	267050			
	Census Bed Type:				
	SNF/NF: 55				
	Total: 55				
	Cancus Payar Trus				
	Census Payor Type Medicare: 1				
	Medicaid: 48				
	Other: 6				
	Total: 55				
	101. 55				
	These deficiencies	reflect State Findings cited in			
	accordance with 41				
	Quality review com	npleted on April 7, 2025.			
	i • •	• •	ı		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Sherice Ricks administrator 04/18/2025

Any defiency statement 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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SO			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155271	B. WI	NG		04/02/	/2025
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				LEARVISTA PL		
WATERS	OE CASTLETON S	SKILLED NUBSING EACH ITY TH	_				
WATERS	OF CASILETON S	SKILLED NURSING FACILITY, TH		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
F 0550	483.10(a)(1)(2)(b)	(1)(2)					
SS=D	Resident Rights/E						
Bldg. 00		<b></b>					
5	Based on interview	and record review, the facility	F 05	550	F 550		04/25/2025
		sident's right for dignity to 2 of	1 0.	750	Preparation and/or execution of	of	0 1/23/2023
		d for timely response to call			this plan of correction in gener		
	lights and 1 of 1 res				or this corrective action does r		
	_	y offering an incontinence			constitute an admission of		
	brief. (Resident C a				agreement by this facility of the	e	
		,			facts alleged or conclusions se		
	Findings include:				forth in this statement of		
	8				deficiencies. The plan of corre	ction	
	1. In an interview v	vith Resident C on 3-31-25 at			and specific corrective actions		
	1:46 p.m., she indicate	ated the minimum amount of			prepared and/or executed in		
		er call light answered was			compliance with State and Fed	deral	
		s and this reflected all shifts,			Laws. Facility's date of alleged		
		shift. She indicated she had			compliance is 4/25/2025. Faci		
		ne facility for over five years.			is respectfully requesting pape	•	
					compliance for all deficiencies		
	The clinical record	of Resident C was reviewed on			this POC.		
	3-31-25 at 12:05 p.r	n. Her most recent Minimum			It is the intent of this facility to		
	Data Set assessment	t, dated 3-15-25, indicated she			answer call lights in a timely		
	was cognitively inta	act.			manner.		
					What corrective action will be		
	2. In an interview v	vith a family member of			accomplished for those reside	nts	
	Resident F on 4-1-2	5 at 2:46 p.m., she indicated			found to have been affected b	y the	
	earlier in the day, th	e resident had activated the			deficient practice		
	call light to request	toileting assistance. She			The DON/Designee assessed		
	added the call light	had been on for about 20			resident C on 4/18/2025, no		
	minutes when she (t	the family member) then went			negative outcome related to th	ıe	
	to the nurse's station	n and found several staff			alleged cited practice. Resider	nt F	
	members present an	d requested they assist the			no longer resides in the facility	/	
		ng. She indicated she left the			How other residents having the	е	
		ely 10 minutes and upon			potential to be affected by the		
	return, was informed	d by the staff that the resident			same deficient practice will be		
		ne indicated when she returned			identified and what corrective		
		m, she found the resident still			action will be taken.		
		ce. She indicated in the recent			All residents that reside in the		
	_	ed phone calls from the			facility have the potential to be	<del>;</del>	
	resident that she had	d her call light on for 30			affected by the cited practice,		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/02/2025 155271 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8400 CLEARVISTA PL WATERS OF CASTLETON SKILLED NURSING FACILITY, THE INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE minutes or more without a staff response and had therefore, this plan of correction asked her to call the facility's main line to gain applies to all residents that reside access for assistance for the resident. in the facility. What measures will be put in The family member indicated since Resident F was place and what systemic changes admitted over one month ago, the resident has will be made to ensure that the been offered by staff to wear an incontinence deficient practice does not recur. brief. "They kept offering her a diaper and we The Director of Nursing or have refused it every time. After a week of being designee will have completed told this, we told them not to offer that anymore. education with staff on answering That is humiliating for anyone, but someone as call lights timely by 4/23/2025. young as she is." Additionally, any employee who fails to comply with the points of The clinical record of Resident F was reviewed on the in-service may be further 4-2-25 at 11:14 a.m. Her admission Minimum Data educated and/or progressively Set assessment, dated 2-19-25, indicated she was disciplined as indicated less than 50 years old, was cognitively intact, was How the corrective action will be non-ambulatory, required substantial assistance monitored to ensure the deficient from staff for toileting and was occasionally practice will not recur, i.e what incontinent of urine and frequently incontinent of quality assurance program will be stool. put into place The DON/Designee will audit call In an interview with the Director of Nursing light response times on 20 random (DON) on 4-2-25 at 10:05 a.m., he indicated it residents on random shifts weekly would be difficult to put a numeric value on how x 4 weeks, then 10 random quickly he expected call lights to be answered, as residents on random shift weekly it was dependent on time of day and what might x 4 weeks, then 5 random be going on in the facility, but expected the staff residents monthly x 4 months. If to respond as quickly as possible to all call lights. the facility is within 95% compliance at the end of the 6 On 4-1-25 at 2:30 p.m., the DON provided a copy months; then monitoring can be of a policy entitled, "Call Light, Use of," with a stopped. Results of the monitoring review date of 1-1-2020. This policy indicated its will be reviewed at the monthly purpose as, "To respond promptly to resident's QAPI meeting. Any concerns will call for assistance...All facility personnel must be have been addressed. However, aware of call lights at all times. Answer ALL call any patterns will be identified. Any lights promptly whether or not you are assigned needed Action Plan will be written to the resident..." by the QAPI committee. Any written Action Plan will be On 4-2-25 at 4:35 p.m., the Corporate Nurse monitored by the Administrator

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETE			ETED	
		155271	B. W	NG	_	04/02/	2025
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	lE	STREET ADDRESS, CITY, STATE, ZIP COD 8400 CLEARVISTA PL INDIANAPOLIS, IN 46256		•	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0580 SS=D	dated 8-9-2023. The be polite and respect be allowed to wear possibleStaff will preferences as much resident have an epi will change them up.  This citation relates  3.1-3(t)  3.1-3(u)(3)  483.10(g)(14)(i)-(iv)	n as possibleShould a isode of incontinence, staff pon discovery of the episode."  to Complaint IN00451947.			weekly until resolved. By what date the systemic changes for each deficient will completed. Date: 4/25/2025	be	
Bldg. 00	A. Based on intervifacility failed to ens and family were not significant weight to of 2 residents review (Resident G)  B. Based on intervifacility failed to ens and family were not new open area to a residents reviewed a condition. (Resident Findings include:  A. During an interval family member of during the previous in Resident G's room Resident G had severesulting in signification.	(Injury/Decline/Room, etc.)  iew and record review, the sure the attending physician tified in a timely manner of a loss in less than 30 days for 1 wed for gastric feedings.  Iew and record review, the sure the attending physician tified in a timely manner of a resident's neck for 1 of 2 for notification of change in t D)  It we on 4-1-25 at 3:56 p.m., with the Resident G, she indicated night, she had spent the night m, at his request. She explained eral strokes during 2024, ant paralysis and an inability thus causing him to require a	F 05	580	F 580 – notification of changes family and physician. It is the intent of this facility is ensure all proper notifications made in relation to a resident's change in condition.  1. What corrective action will be accomplished by the resident found to have been affected be deficient practice? Resident D's family and physic were notified of the open area the neck on 3/24/2025. Resident G no longer resides the facility.  2. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The DON/Designee will have completed an audit on the residents with a wound for	to are s pe y the cian on in	04/25/2025

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155271	B. W	ING		04/02/	2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	t			LEARVISTA PL		
WATERS	S OF CASTLETON:	SKILLED NURSING FACILITY, TH	F		APOLIS, IN 46256		
	ı						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	"feeding tube."				physician and family notification		
		CD 11 . G			by 4/18/2025, any notification	not	
		of Resident G was reviewed on			done was completed on		
		His diagnoses included, but			4/18/2025.		
	were not limited to, encephalopathy, cerebral				The DON/Designee will have		
		iplegia and hemiparesis			completed a 30 day look back		
		ide, general muscle weakness,			residents with a weight loss ar		
	_	ny (feeding tube) status. His			notified the physician and fam	ııy	
		num Data Set (MDS)			as needed by 4/23/2025.		
		-5-25, indicated he was y impaired, did not receive oral			3. What measures will be put i		
		ved 51 or more percent (%) of			place and what systemic chan	-	
		nteral feedings and received			will be made to ensure that the		
		of enteral nutrition daily. It			deficient practice does not rec		
		recent weight was 205 pounds			The DON/Designee in-service	a ine	
		if this was reflective of any			nursing staff on notification of	n a o	
	weight gain or weig	<del>-</del>			family and physician for a challing and ities to include a weigh	-	
	weight gain of weig	iit ioss.			in condition to include a weigh loss and a new wound.	ı	
	A raviany of Dacida	nt G's physician orders,					
		ndicated he was to receive an			Additionally, any staff member that fails to comply with the po		
		orand name of liquid nutrition)			of this in-service will be further		
		ablespoons) per hour, for a total			educated and/od disciplined a		
		every 24 hours. It also indicated			indicated.	3	
		ye anything by mouth. An			4. How the corrective action w	ill he	
		, indicated to obtain his weight			monitored to ensure the deficient		
		en weekly for four weeks, then			practice will not recur, what qu		
		monthly on Mondays.			assurance program will be put	-	
		,			place?		
	Resident G's initial	weight, on 1-7-25, was			The DON/Designee will review	v	
		ounds, followed by a weight			progress notes for change in	-	
	_	0 pounds, then a weight on			condition and notification of fa	milv	
	1	unds. This reflected a			and physician five times a wee	-	
	_	oss of 30.7 pounds or more			4 weeks, then 3 times a week		
	1 -	an one month. His clinical			weeks, then once a week x 4		
		sident G had been hospitalized			months. If the facility is within		
		7-25, and from 2-20-25 to 2-28-25.			95% compliance at the end of	the	
					6 months; then monitoring car		
	An interdisciplinary	notation, dated 3-5-25,			stopped. Results of the monitor		
		G had been recently readmitted			will be reviewed at the monthly	•	
		eceived "tube feedings." It			QAPI meeting. Any concerns v		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155271	B. WI	NG		04/02/	2025
				CTDEET 4	DDDESC OITY STATE ZIR COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	OF OACTI FTON	OKULI ED NUIDOINO EA OULTV. TU	_		LEARVISTA PL		
WATERS	OF CASILETON	SKILLED NURSING FACILITY, TH	E	INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	reflected a weight o	f 205.0 pounds, but did not			have been addressed. However	er,	
		oss or gain. It indicated his			any patterns will be identified.		
	"Food Intakes," as "Fair." and he received enteral				needed Action Plan will be wri	-	
		liters per hour. It did not			by the QAPI committee. Any		
	_	e, "NPO [nothing by mouth]."			written Action Plan will be		
		sician, and family had been			monitored by the Administrato	r	
	notified of this info				weekly until resolved.		
					5. By what date the systemic		
	A second interdiscip	plinary notation, dated 3-12-			changes for each deficiency w	rill	
		weight of 206.0 pounds, on 3-			be completed?		
	_	same information. The			Date: 4/25/2025		
	_	m notations failed to identify			Bato. 1/20/2020		
		ht loss until a notation from					
	"dietary," on 2-19-2						
		veight] gain 5% x 30 days- not					
		me, likely due to previous tube					
		takes. Further wt gain not					
		t [Continue] to monitor weekly					
		linary team]." Specific					
		ed to reflect the attending					
		had been notified of the					
		oss on the above dates.					
	significant weight it	oss on the above dates.					
	A notation dated 2	-26-25, from the Registered					
		cated Resident G's current					
		ands was a significant weight					
		ay period. It identified a					
		racy of the documented					
	_	2-17-25, as well as changes					
		t's enteral feeding orders,					
		higher rate previously. The					
		he plan of action was to					
		Resident G in the weekly					
		eetings, related to the enteral					
		tion did not reflect the					
		, or family had been notified of					
	the significant weig	ht loss on this date.					
		n the Director of Nursing					
	(DON) on 4-2-25 at	2:02 p.m., he indicated					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155271	B. WI	NG		04/02/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				LEARVISTA PL		
\\/\\TED	COE CASTI ETONI	SKILLED NURSING FACILITY, TH	_		APOLIS, IN 46256		
WATERS	OF CASTLETON	SKILLED NORSING FACILITY, TH		INDIAN	AFOLIS, IN 40230		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	. =	DATE
	Resident G was foll	owed by the interdisciplinary					
	team on a weekly be	asis due to receiving tube					
	feedings. He indicat	ted the RD was aware of					
	Resident G's weight loss.						
	B. The clinical reco	rd of Resident D was reviewed					
	on 4-1-25 at 11:01 a	a.m. It indicated his diagnoses					
	included, but were i	not limited to, acute and					
	chronic respiratory	failure with hypoxia, metabolic					
	encephalopathy, tra	cheostomy status and					
	dysphagia. His mos	t recent Minimum Data Set					
	(MDS) assessment,	dated 1-25-25, indicated he					
	was severely cognit	ively impaired, was nonverbal,					
	nonambulatory, and	was dependent on staff for all					
	activities of daily ca	are. It indicated he had a					
	-	racheostomy (trach), which					
	-	oport and tracheostomy care,					
		g. It indicated he did not have					
	-	but did have an open area to					
		e associated skin damage.					
		5					
	In an interview on 4	1-2-25 at 12:30 p.m., with a					
		Resident D, she indicated, "I					
		or a visit and I did not see any					
		kin. The next day, at his					
	*	ent, I saw there was something					
		s lean his head to the left a lot					
		ess is the trach collar elastic					
		ed to the place on his neck."					
	-	as taken directly to the					
		R) after his radiology					
		ther treatment and evaluation.					
		indicated she had not been					
	-	skin concerns prior to noticing					
	-	neck at the radiology					
	•	4-25. She estimated the time of					
		ntment was mid to late					
		ated she did not see a dressing					]
	-	_					
	_	open area, but there was ge present to the trach tube					
	some bloody draina	ge present to the trach tube					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155271		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY COMPLETED 04/02/2025	
	PROVIDER OR SUPPLIER  S OF CASTLETON SKILLED NURSING FACILITY, TH	8400 CI	ADDRESS, CITY, STATE, ZIP COD LEARVISTA PL APOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  ties and to the linen around/under the neck area.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	A review of the clinical record indicated a  "Weekly Skin Check" form, dated 3-24-25 at 8:39 a.m., indicated Resident D had a newly open area. An accompanying document, also dated 3-24-25 at 8:39 a.m., entitled, "Weekly Wound Event," indicated a new "laceration," had been identified on that date to the left side of his neck, measuring 5.1 centimeters (cm) by 0.1 cm with a depth of 0.2 cm. It indicated a small amount of serosanguinous (combination of clear fluid and blood) drainage. It listed only "steri strips" as the current treatment. It indicated, on 3-24-25, the attending physician was aware and the responsible party "updated on wound status."  The clinical record documentation failed to identify when the open area was initially identified and what treatment, if any, was conducted prior to the "Weekly Skin Check" being conducted. The nursing progress notes failed to identify any notifications to the facility administration of the new open area and the time of Resident D's departure from the facility to the radiology appointment. The DON indicated, on 4-1-25 at 11:35 a.m., he would provide a copy of the emergency room visit of 3-24-25, but did not provide the documentation prior to exit on 4-2-25.  In an interview with the DON on 4-2-25 at 10:05 a.m., he indicated the nurse on duty for the night shift, of 3-23-25 until the morning of 3-24-25, had notified him, on 3-24-25, close to 7:00 a.m., that a new open area to the left side of Resident D's neck had been identified about an hour earlier and had cleaned it up and covered it with a dressing. "I told them that was fine and that I would have the wound nurse look at it as soon as she got there that morning. I went in with the wound nurse				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155271		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/02/2025	
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	8400 CI	ADDRESS, CITY, STATE, ZIP COD LEARVISTA PL APOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	looked like the elast kind of cut into his tried to pad it good DON indicated he of from the nurse who area and had made the wound nurse do thereafter.  On 4-2-25 at 4:18 p provided a copy of for Notification of Condition/Status/Trindicated, "It is the that the resident, the the resident's Responsible of changes in the retreatment. This not in order to obtain an appropriate treatment the change—as well right related to mak care preferences	nen we found the laceration. It ic from the trach mask had neck. We cleaned it up and with gauze squares." The id not see any documentation originally identified the open nim aware of the situation, but cumented her findings shortly  .m., the Corporate Nurse a policy entitled, "Guidelines Change in Resident's eatment," dated 6-29-2024. It intent of the facility to ensure cir attending physician, and insible Party/POA are notified sident's condition, status or iffication will be done promptly my orders needed for an and/or monitoring related to as to promote the resident e choices about treatment and otification is provided to the te continuity of care and to be physician about appropriate es which can include continuation of, current ated to the notification. Indeed to the resident and/or the ole Party/POA in conjunction that to make choices about care to keep them informed of the earth statusrelated to the call the statusrelated to the call the statusrelated to the call the complaint informed of the statusrelated to the call the complaint informed of the call the statusrelated to the call to Complaint informed of the call the statusrelated to the call to Complaint informed of the call the statusrelated to the call to Complaint informed of the call the complaint informed of the call the statusrelated to the call to Complaint informed of the call the complaint informed of the call the statusrelated to the call the complaint informed of the call t			

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Event ID:

8HIT11

Facility ID: 000171

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155271	B. WI	NG		04/02/	/2025
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			LEARVISTA PL		
\M\ATEDS	COE CASTI ETON	SKILLED NURSING FACILITY, TH	_		APOLIS, IN 46256		
WATERC	OI CASTLLION	SKILLED NORSING FACILITY, 111		INDIAN	AI OLIO, III 40200		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0656	483.21(b)(1)(3)						
SS=D		nt Comprehensive Care Plan					
Bldg. 00		·					
	Based on interview	and record review, the facility	F 06	556	F656 Develop/Implement		04/25/2025
	failed to develop a comprehensive care plan for 1				Comprehensive Care Plan		
	of 5 residents review	wed for bathing and hygiene			What corrective action will be		
	care needs. (Reside	ent B)			accomplished for those reside	nts	
					found to have been affected b	y the	
	Findings include:				deficient practice:		
					It is the policy of the facility tha	at	
	The clinical record	of Resident B was reviewed on			the facility must develop and		
		<ul> <li>His diagnoses included, but</li> </ul>			implement a comprehensive		
		pneumonia, unspecified			person-centered care plan for	each	
	· ·	rspecified abnormalities of gait			resident, consistent with reside	ent	
		tive communication deficit and			rights, that includes measurab	le	
	-	kness. His admission			objectives and timeframes to r	neet	
		(MDS) assessment, dated			a resident's medical, nursing,		
		he was moderately cognitively			self-care, mental, and		
		moderate assistance from staff			psychosocial needs that are		
	-	ering, and supervision from			identified in the comprehensiv	е	
	staff for hygiene car	re.			assessment.		
					How other residents having th		
		n a family member of Resident B			potential to be affected by the		
		a.m., he indicated Resident B			same deficient practice will be		
	received very few s	howers while at the facility.			identified and what corrective		
					action will be taken:		
	_	are plan was not located in			All residents that currently res		
		l record for assistance with			in the facility have the potentia		
		ving (ADL's) or specifically for			be affected by the alleged defi		
	bathing and hygiene	e care needs.			practice. The MDS or designe		
	In an interview	1 1 25 at 0:40 a m with the			completed a facility wide audit		
		4-1-25 at 9:40 a.m. with the			update all current resident's ca	яе	
		(DON), he indicated the e a care plan for this resident's			plans related to ADL abilities		
	ADL's.	a care plan for this residents			What measures will be put in	ngos	
	ADL 8.				place and what systemic chan will be made to ensure that the	-	
	In an interview on /	1-1-25 at 11:04 a.m. with the			deficient practice does not rec		
	In an interview on 4-1-25 at 11:04 a.m. with the MDS Coordinator, she indicated, "It looks like I				The MDS Consultant educated		
		care plan for ADL's, based on			MDS Coordinator on 4/15/202		
		and the baseline care			the care plan process.	5 011	
	are administration wide	and the outerine care	I		i ilio caro piari process.		I

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155271	B. WI	NG		04/02	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	ł.			LEARVISTA PL		
WATERS	OF CASTLETON	SKILLED NURSING FACILITY, TH	E		APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	planThe baseline	care plan is done by the			Additionally, any employee wh	10	
	admitting nurse, usi	ually on the same day they are			fails to comply with the points	of	
		on what that nurse sees and			the in-service may be further		
	· ·	e Admission MDS is			educated and/or progressively	′	
		at first week or so while the			disciplined as indicated.		
	nursing staff can actually see how well the new				How the corrective action will		
	admission [resident] is doing and what I can				monitored to ensure the defici-		
		the process of that first MDS			practice will not recur, i.e what	t	
	assessment."				quality assurance program wil	l be	
					put into place:		
		p.m., the DON provided a copy			The "F656 – Develop and		
		"Baseline Care Plan			Implement Comprehensive Ca		
		ehensive Care Plans," updated			Plan Audit" will be a full house		
		s policy indicated, "It is the			audit of ADL care plan for curr	ent	
		y to ensure that every resident			residents. Any ADL care plan		
		Plan completed and			missing will be documented or		
	_	1 48 hours of AdmissionThe			audit worksheet and added to		
		will be discontinued upon the			resident's comprehensive care	<del>)</del>	
	-	Comprehensive Care Plan. The			plan. Going forward, any new		
	_	re Plan will further expand on			admission or readmissions to		
		goals and interventions using			facility weekly, in addition to a	-	
		d' Plan of Care approach for			OBRA MDS completed weekly	y will	
		ncludes measurable objectives			be audited for ADL care plan		
		eet the resident's medical,			accuracy and completion x 12		
		inctioning, mental and			weeks. Results of the monitori	-	
	psychosocial needs.	"			will be reviewed at the monthly		
	TELL 1/21 1 1	4 C 1 ' 4 DI00450054			QAPI meeting. Any concerns		
	i his citation relates	to Complaint IN00450054.			have been addressed. Howev	•	
	2.1.25(-)				any patterns will be identified,		
	3.1-35(a)				any needed Action Plans will b		
	3.1-35(b)(1)				written by the QAPI committee		
					Any written Action Plan will be		
					monitored by the Administrato	r	
					weekly until resolved.		
					By what date the systemic		
					changes for each deficient will	pe	
					completed.		
					Date: 4/25/2025		
			I				I

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155271	B. WI	NG		04/02	/2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	COE CASTI ETONI	SKILLED NURSING FACILITY, TH	_		IAPOLIS, IN 46256		
VVATERS	OF CASILETON (	SKILLED NORSING FACILITY, IT	<u>.                                    </u>	וואטואוי			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0677	483.24(a)(2)						
SS=D	ADL Care Provide	ed for Dependent Residents					
Bldg. 00							
		and record review, the facility	F 06	577	F 677		04/25/2025
	-	thing and/or showering care			It is the intent of this facility to		
		reviewed for bathing and			provide Activities of Daily Livir	ng for	
	hygiene care needs.	(Resident B)			bathing and hygiene care.		
					What corrective action will be		
	Findings include:				accomplished for those reside		
					found to have been affected b	y the	
		of Resident B was reviewed on			deficient practice.		
		n. His diagnoses included, but			Resident B no longer resides	in	
		pneumonia, unspecified			the facility.		
	· ·	rspecified abnormalities of gait			How other residents having th		
		tive communication deficit, and			potential to be affected by the		
	-	kness. His admission Minimum			same deficient practice will be	!	
		sessment, dated 12-12-24,			identified and what corrective		
		oderately cognitively impaired,			action will be taken.		
	-	assistance from staff for			The DON/Designee interviewe		
	-	ng and supervision from staff			residents for bathing and hygi		
		d it was "very important," for			preferences and will be updati	-	
		oose what manner of bathing			the residents Activities of Daily		
		s tub bath, shower, bed bath or			Living Care Plan by 4/23/2025	j.	
	sponge bath.				What measures will be put in		
					place and what systemic chan	•	
		a family member of Resident B			will be made to ensure that the	_	
		a.m., he indicated Resident B			deficient practice does not rec		
	received very few s	howers while at the facility.			The DON or designee will have		
					education completed by 4/23/2	2025	
		1-1-25 at 11:04 a.m., with the			to the nursing staff relating to		
	· · · · · · · · · · · · · · · · · · ·	she indicated "It looks like I			bathing and hygiene per resid		
	_	care plan for ADL's [activities			preferences. Additionally, any		
		ed on the admission MDS and			employee who fails to comply		
	-	anThe baseline care plan is			the points of the in-service ma	y be	
	-	ng nurse, usually on the same			further educated and/or		
		ed. It's based on what that			progressively disciplined as		
		ld initially. The admission			indicated.		
		within that first week or so			How the corrective action will		
	-	aff can actually see how well			monitored to ensure the defici		
	the new admission [	resident] is doing and what I	I		practice will not recur, i.e what	t	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155271	B. W	ING		04/02/	2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
\\/\TED	OF CASTLETON	SKILLED MUDSING FACILITY TH			LEARVISTA PL		
WATERS	OF CASTLETON	SKILLED NURSING FACILITY, TH	IC.	INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	can assess while I a	m in the process of that first			quality assurance program will	be	
	MDS assessment."				put into place.		
					The DON/Designee will audit	10	
	A review of Reside	nt B's bathing records for			random residents for		
	12/2024, indicated l	his "Bathing Choice Provided"			bathing/showering and hygien	e per	
	was scheduled for N	Monday and Thursday			residents' preferences and car	-	
	evenings. It indicated he received three bed baths,				plan weekly x 4 weeks, then 5		
	one partial bath and no showers for the 25 days of				random residents weekly x 4		
	December he was present in the facility. His				weeks, then 3 random residen	ts	
	bathing records for 1/2025, indicated his "Bathing				monthly x 4 months. If the faci	lity	
	Choice Provided" was scheduled for Monday and				is within 95% compliance at th	е	
	Thursday evenings. It indicated he received three				end of the 6 months; then		
	partial baths and one shower in the 30 days of				monitoring can be stopped.		
	January he was pres	sent in the facility.			Results of the monitoring will be	e	
					reviewed at the monthly QAPI		
		ed a copy of an "I Would Like			meeting. Any concerns will ha	ve	
		so known as a grievance form.			been addressed. However, an	у	
		2-25, indicated the facility's			patterns will be identified. Any		
		signee (SD) had documented			needed Action Plan will be wri	tten	
		sident B had questions			by the QAPI committee. Any		
		shower schedule was. A			written Action Plan will be		
	_	m, dated 1-2-25, indicated the			monitored by the Administrato	r	
		nt to the attention of the			weekly until resolved.		
		on the same date. It indicated			By what date the systemic		
		included contacting the son			changes for each deficient will	be	
		form him to explain, "the			completed.		
		otocolexplained to son and			Date: 4/25/2025		
	l -	of Resident B] can take					
		erred times due to his level of					
		wer given same day." The					
		tion for 1-2-25, did not reflect					
	bathing of any type	was provided to Resident B.					
	This citation relates	to Complaint IN00450054.					
	3.1-38(a)(2)(A)						
	3.1-38(a)(3)(B)						
F 0692	483.25(g)(1)-(3)						
SS=D	Nutrition/Hydration	n Status Maintenance					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. Building <u>00</u>			COMPLETED	
		155271	B. WING			04/02/2025	
				_			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
			_		LEARVISTA PL		
WATERS	OF CASILETON	SKILLED NURSING FACILITY, TH	E	INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	·-	DATE
Bldg. 00							
	Based on interview	and record review, the facility	F 06	592	F 692 Nutrition/Hydration Stat	us	04/25/2025
	failed to ensure a re	sident receiving continuous			Maintenance		
	enteral (gastric) fee	dings received feedings as			It is the policy of this facility to		
	ordered and a signif	ficant weight loss occurring in			ensure residents receiving		
	less than 30 days wa	as identified and timely			continuous tube feedings and	а	
	interventions related	d to the weight loss were			significant weight loss have tir		
		2 residents reviewed for gastric			interventions.	-	
	feedings. (Resident	t G)			1. What corrective actions will	be	
					accomplished for those reside	nts	
	Findings include:				found to have been affected b	y the	
					deficient practice.		
	During an interview	on 4-1-25 at 3:56 p.m., with a			Resident G no longer resides	in	
	family member of R	Resident G, she indicated during			the facility.		
	the previous night,	she had spent the night in			2. How other residents having	the	
	Resident G's room,	at his request. She explained			potential to be affected by the		
	Resident G had seve	eral strokes during 2024,			same deficient practice will be		
	resulting in significa	ant paralysis and an inability			identified and what corrective		
	to swallow safely, the	hus causing him to require a			actions will be taken.		
	"feeding tube." She	e indicated sometime between			The DON/Designee will have		
	2:00 a.m. and 4:00 a	a.m., on 4-1-25, the continuous			completed a 30 day look back	of	
	feeding had run out	and it had not been resumed			weights and implemented		
	prior to her leaving	the facility later that morning			interventions as needed by		
	at 8:20 a.m. She ind	licated the nursing staff			4/23/2025.		
		ason the feeding was not			3. What measures will be put i	in	
		se the needed feeding solution			place and what systemic chan	ges	
	was locked in an of	fice in the facility and was not			will be made to ensure that the	е	
	accessible to the nu	rsing staff.			deficient practice does not rec	ur.	
					The ADM/Designee completed	d an	
		the Director of Nursing			in-service with the RD and nur	rsing	
	` '	9:45 a.m., he indicated he had			on monitoring of weights and		
		re of any issues regarding			reporting weight loss to the		
		g being unavailable during the			dietitian and implementing		
	_	lay night. In an interview with			interventions. Additionally, any		
		later, he indicated he had			staff that fails to comply with the		
	_	out to the nurse who had been			points of this in-service will be		
		time but had to leave a			further educated and/or discip	lined	
	-	se to return his call. In an			as indicated.		
	interview with the I	OON on 4-2-25 at 3:05 p.m., he			4. How the corrective action w	ill be	
	indicated the nurse	had called back and confirmed			monitored to ensure the defici-	ent	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155271		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/02/2025			
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	STREET ADDRESS, CITY, STATE, ZIP COD  8400 CLEARVISTA PL  INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Resident G's feeding 3:00 a.m., on 4-1-22 having been locked staff. He indicated 4-1-25 at 8:30 a.m.  The clinical record 4-2-25 at 1:46 p.m. were not limited to, infarction with hem affecting the right stabletes, gastroston re-admission Minim assessment, dated 3 severely cognitively nutrition, and receiv his nutrition from errover 500 milliliters indicated his most rebut did not indicate weight gain or weig G's medication adm administration recornotes did not indicate enteral feeding had  A review of Resider effective 2-17-25, in enteral feeding of (to 60 milliliters (2 to f 1,440 milliliters (2 to f 1,440 milliliters (2 to of 1,440 milliliters (2 to of 1,440 milliliters (3 to obtain his weight Resident G's initial as 220.6 pounds, for of 236.0 pounds, the	g had run out at approximately b, due to the feeding solution up and inaccessible to the the feeding was resumed on  of Resident G was reviewed on His diagnoses included, but encephalopathy, cerebral iplegia and hemiparesis ide, general muscle weakness, by (feeding tube) status. His hum Data Set (MDS)  -4-25, indicated he was impaired, did not receive oral red 51 or more percent (%) of interal feedings and received of enteral nutrition daily. It eccent weight was 205 pounds, if this was reflective of any th loss. A review of Resident inistration record, treatment and and the nursing progress te any interruptions of the		practice will not recur, i.e what quality assurance program will put into place.  DON/Designee will monitor weights weekly for changes a implementation of intervention months. If the facility is within 95% compliance at the end of months, the monitoring will be stopped. During the monthly 0 meeting, monitoring will be reviewed, and any concerns whave been corrected as found patterns will be identified. If necessary, an Action Plan will written by the committee. Any written Action Plan will be monitored by the Administrato weekly until resolution.  5. By what date the systemic changes for each deficiency who be completed.  Date: 4/25/2025	t I be I be Ind Is x 6 I 4 IQAPI Vill I. Any be		

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Facility ID: 000171

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155271	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/02/2025			
NAME OF PROVIDER OR SUPPLIER WATERS OF CASTLETON SKILLED NURSING FACILITY, THE			STREET ADDRESS, CITY, STATE, ZIP COD  8400 CLEARVISTA PL  INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION  e than 10% in less than one	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	month. His clinical	record indicated Resident G ed from 2-1-25 to 2-17-25, and						
	indicated Resident ( to the facility and re reflected a weight o reflect any weight le "Food Intakes" as " enteral feedings at ( indicate he was to b	or notation, dated 3-5-25, G had been recently readmitted beeived "tube feedings." It if 205.0 pounds, but did not loss or gain. It indicated his Fair" and that he received milliliters per hour. It did not lose "NPO [nothing by mouth]." sician, and family had been remation.						
	25, with an updated 11-25, provided the interdisciplinary tea the significant weig "dietary", on 2-19-2 sig wt [significant v of concern at this tin feed + [plus] oral in recommended. Con on swat [interdiscip documentation faile physician or family	weight of 206.0 pounds, on 3-same information. The sum notations failed to identify th loss until a notation from 25, indicated "triggering for weight] gain 5% x 30 days- not me, likely due to previous tube stakes. Further wt gain not t [Continue] to monitor weekly linary team]." Specific and to reflect the attending had been notified of the loss on the above dates.						
	Dietitian (RD), indi weight of 208.5 por loss of 5% in a 30 d concern of the accu weight obtained, on made to the residen which had been at a	c26-25, from the Registered cated Resident G's current ands was a significant weight ay period. It identified a racy of the documented 2-17-25, as well as changes t's enteral feeding orders, a higher rate previously. The the plan of action was to						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155271		A. B	A. BUILDING 00  B. WING			COMPLETED 04/02/2025	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	НE	8400 CL	.DDRESS, CITY, STATE, ZIP COD LEARVISTA PL APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	interdisciplinary me nutrition. This notat	Resident G in the weekly settings, related to the enteral stion did not reflect the , or family had been notified of ht loss on this date.					
	(DON) on 4-2-25 at Resident G was foll team on a weekly be feedings. He indicat Resident G's weight	the Director of Nursing 2:02 p.m., he indicated owed by the interdisciplinary asis due to receiving tube ted the RD was aware of t loss. He indicated missing enteral feeding, on 4-1-25, f concern.					
	of policy entitled, "Adult," dated 7-3-20 purpose was "To pr licensed clinical sta and managing and a and Enteral Nutritic review the order for advancement instru The formula will be stored until use in a proper temperature	c.m., the DON provided a copy Guidelines for Enteral Feeding: 023. This policy indicated its ovide guidance to qualified ff in hanging and maintaining administering Tube/Feedings on to residentsThe nurse will type of formula, rate and ctions, all associated orders. The retrieved from where it is clean/dry area and at the for stabilityWeigh the or as ordered (usually M-W-F)					
	provided a copy of for Notification of Condition/Status/Trindicated, "It is the that the resident; the the resident's Response of changes in the retreatment. This not	.m., the Corporate Nurse a policy entitled, "Guidelines Change in Resident's reatment," dated 6-29-2024. It intent of the facility to ensure eir attending physician, and onsible Party/POA are notified sident's condition, status or ification will be done promptly my orders needed for					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155271		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  04/02/2025		
NAME OF PROVIDER OR SUPPLIER  WATERS OF CASTLETON SKILLED NURSING FACILITY, THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD  8400 CLEARVISTA PL  INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
F 0842 SS=D Bldg. 00	the changeas well right related to make care preferencesN physician to facilita obtain input from the interventions/chang additions to, or disc care/treatmentsrelations (and treatmentsrelations) with the resident rigand treatment and to resident's current he notification."  3.1-46(a)(1) 3.1-46(a)(2)  483.20(f)(5), 483.7 Resident Records  Based on interview failed to thoroughly regarding the identition open area and inform of a change in condition the new open area for tracheostomies (tracked) tracked (tracked) the clinical record (and the tracked) that the clinical record (and the tracked) that the clinical record (and the tracked) are chronic respiratory and the clinical record (and the tracked) assessment, that the clinical record (and the tracked) assessment, that the clinical record (and the tracked) assessment, assessment, assessment, assessment, assessment, and the clinical record (and the tracked) assessment, assessment, assessment, assessment, assessment, assessment, and the control of the clinical record (and the tracked) assessment, assessment, assessment, assessment, assessment, and the control of the clinical record (and the tracked) assessment, assessment, assessment, assessment, assessment, and the control of the clinical record (and the tracked) assessment, assessment, assessment, assessment, assessment, and the control of the clinical record (and the tracked) assessment, a	- Identifiable Information  and record review, the facility document information fication of a newly identified mation regarding notification ition to the family regarding for 1 of 2 residents reviewed for	F 08	342	Tag# 842 Resident Records-Identifiable Information It is the policy of this facility to document a newly identified wound and notification of the family and physician of the chain condition. What corrective actions will be accomplished for those reside found to be affected by the deficient practice: The DON/Designee completed wound assessment for resider on 3/24/2025 and notified familiand physician on 3/24/2025. How other residents having the potential to be affected by the same deficient practices will be	nts d the nt D dily	04/25/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPL	COMPLETED	
		155271	B. WING 04/02/2025			2025	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	OF OACT! ETON (	OKUL ED NUIDOINO EAGULTY TU	_		LEARVISTA PL		
WATERS	OF CASTLETON	SKILLED NURSING FACILITY, TH	E	INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	nonambulatory, and	was dependent on staff for all			identified and what corrective		
		are. It indicated he had a			action will be taken:		
	feeding tube and a t	racheostomy, which required			The DON/Designee completed	d an	
	-	tracheostomy care, including			audit of residents with wounds		
		ated he did not have any			verified documentation was		
	-	did have an open area to his			completed for the assessment	of	
	-	ssociated skin damage.			the wound and notification of t		
		Ç			family and physician 4/18/202		
	In an interview on 4	1-2-25 at 12:30 p.m. with a			What measures will be put in		
		Resident D, she indicated, "I			place and what systemic chan	aes	
		or a visit and I did not see any			will be made to ensure that	3	
		kin. The next day, at his			deficient practice does not rec	ur.	
	-	ent, I saw there was something			DON/Designee will in-service		
		s lean his head to the left a lot			nursing staff on completing a		
		ess is the trach collar elastic			wound assessment upon		
		ed to the place on his neck."			discovery of a wound and noti	fvina	
		s taken directly to the			the family and physician on	.,9	
		R) after his radiology			4/23/2025. Additionally, any st	aff	
		ther treatment and evaluation.			member that fails to comply w		
		indicated she had not been			the points of this in-service wil		
		skin concerns prior to noticing			further educated and/or discip		
	-	neck at the radiology			as indicated.		
		4-25. She estimated the time of			How the corrective actions will	be	
	* *	ntment was mid to late			monitored to ensure the defici		
		ated she did not see a dressing			practices will not recur:	0111	
		open area, but there was			DON/Designee audit progress		
	•	ge present to the trach tube			notes five time a week for new		
	_	around/under the neck area.			open areas for completion of		
					assessment and family/physic	ian	
	A review of the clin	ical record indicated a			notification x 4 weeks then 3		
		k" form, dated 3-24-25 at 8:39			times a week x 4 weeks, then		
	-	dent D had a newly open area.			once a week x 4 months. If the	2	
		locument, also dated 3-24-25			facility is within 95% complian		
		d "Weekly Wound Event,"			at the end of the 6 months, the		
		ceration" had been identified			monitoring will be stopped.	•	
		eft side of his neck, measuring			Results of the monitoring will to	ne .	
		) by 0.1 cm with a depth of 0.2			reviewed at the monthly QAPI		
		nall amount of serosanguinous			meeting. Any concerns will ha		
		ar and bloody fluid) drainage.			been addressed. However, an		
		strips" as the current			patterns will be identified. Any	•	
	It have only stell s	surps as the current	1		paucino wiii be luchillileu. Ally		

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STATEMENT OF DEFICIENCIES X1) PROVIDER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
155271		B. WING 04/02/2			2025		
		<u> </u>	Ь,	CTDEET 4	DDDESC OITY STATE ZIR COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
\A/A TEDO	OF OACT! FTON (	OKUL ED NUIDOINO EA OULTV. TU	_		LEARVISTA PL		
WATERS	OF CASTLETON	SKILLED NURSING FACILITY, TH	┖	INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	treatment. It indicate	ed, on 3-24-25, the attending			needed Action Plan will be wri	tten	
	physician was awar	e and the responsible party			by the QAPI committee. Any		
	"updated on wound				written Action Plan will be		
	•				monitored by the Administrato	r	
	The clinical record	documentation failed to			weekly until resolved.		
	identify when the or	pen area was initially identified			By what date the systemic		
		if any, was conducted prior to			changes for each deficient will	be	
		Check" being conducted. The			completed.		
	-	tes failed to identify any			Date: 4/25/2025		
		attending physician, family or					
	facility administration	on of the new open area and					
	the time of Resident	t D's departure from the facility					
	to the radiology app	pointment. The Director of					
	Nursing (DON) ind	icated, on 4-1-25 at 11:35 a.m.,					
	he would provide a	copy of the emergency room					
	visit of 3-24-25, but	t it was not provided prior to					
	exit on 4-2-25.						
	In an interview with	n the DON on 4-2-25 at 10:05					
	a.m., he indicated th	ne nurse on duty for the night					
	shift, of 3-23-25 unt	til the morning of 3-24-25, had					
	notified him on 3-24	4-25, close to 7:00 a.m., that a					
	new open area to the	e left side of Resident D's neck					
	had been identified	about an hour earlier and they					
	_	nd covered it with a dressing.					
	"I told them that wa	s fine and that I would have					
		look at it as soon as she got					
	there that morning.	I went in with the wound					
	-	at's when we found the					
	laceration. It looked	l like the elastic from the trach					
		it into his neck. We cleaned it					
		it good with gauze squares."					
	The DON indicated						
		n the nurse who originally					
	_	area and had made him aware					
		the wound nurse documented					
	her findings shortly	thereafter.					
	On 4-1-25 at 3:15 p	.m., in an interview with the					
	Corporate Nurse, sh	ne indicated the facility does					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED		
155271		B. WING			04/02/2025		
NAME OF PROVIDER OR SUPPLIER WATERS OF CASTLETON SKILLED NURSING FACILITY, THE			E	8400 CI	ADDRESS, CITY, STATE, ZIP COD LEARVISTA PL APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	policy on documentation.  to Complaint IN00456622.					
	3.1-50(a)(3)						

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