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	05/12/2021

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00351583. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00351583 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686. Survey dates: May 12, 2021 Facility number: 000149 Provider number: 155245 AIM number: 100266840 Census Bed Type: SNF/NF: 26 Total: 26 Census Payor Type: Medicare: 3 Medicaid: 16 Other: 7 Total: 26 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 21, 2021	F 0000		
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-			

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

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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure wounds were measured with description upon admission to the facility and weekly thereafter, a treatment was initiated for wounds identified upon admission timely and follow-up with changes in treatment per wound care staff, including changes in treatments and frequency of treatments, for 3 of 3 residents reviewed for skin impairment. (Resident B, C and D) Findings include: 1. The clinical record for Resident B was reviewed on 5/12/21 at 12:23 p.m. The diagnoses included, but were not limited to, paraplegia, malnutrition, pressure ulcer, and muscle weakness. Resident B was admitted to the facility on 3/12/21. A hospital discharge summary, dated 3/12/21, indicated the following instructions, "...Wound Care Instructions...Right Ischium/Right Thigh: Wound VAC...Frequency: Please change 2x/week [two times a week]...Left Groin: Wound VAC...Left Ischium and Sacrum: Wound Dressings...1. Gently cleanse wounds with saline moistened gauze...2. Lightly pack wounds with	F 0686	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or 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 the provisions of federal and state law. Castleton Health Care Center maintains the alleged deficiencies do not individually jeopardize the health and/or safety of its residents nor are they if such character as to limit the provider's capacity to render adequate resident care. Furthermore, Castleton Health Care Center asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and this Plan of Correction in its entirety constitutes the provider's credible allegation of compliance.	05/28/2021

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	Dakin's moistened kerlix [rolled gauze]...3. Cover with ABD [abdominal] pad and secured with Medipore tape...Please change BID [twice daily]...." An admission assessment, dated 3/12/21, indicated Resident B's skin integrity was documented as having a stage 4 wound to right buttock, stage 3 wound to left buttock, and a stage 3 wound to left thigh (rear). There were no descriptions and/or measurements of the wounds noted in Resident B's clinical record upon admission. This assessment did not mirror the hospital discharge summary of Resident B having 5 wounds. The following physician orders were noted for Resident B's wounds upon admission: "Dakin's...Apply to Left Ischium and Sacrum topically two times a day for wound care...." Start date of 3/13/21 at 8:00 p.m. and discontinuation date of 3/15/21. The ETAR indicated only 2 out of the 4 possible administrations were completed for the above order. "Gently cleanse wound with saline moistened gauze Light pack wounds [sic] with Dakins moistened kerlix Cover with ABD [abdominal] pad secured with tape two times a day for wound care...." Start date of 3/13/21 at 8:00 p.m. and discontinuation date of 3/15/21. There was no specific location for the above treatment to be applied to. The ETAR indicated only 2 out of the 4 possible administrations were completed for the above order.		**F-686: Treatment/Svcs to prevent/Heal Pressure ulcers** **A) What corrective action will be accomplished for the residents found to have been affected by this practice?** **a.** On 4/1/2021, resident B discharged against medical advice from the facility. **b.** On 5/26/2021, the DON reviewed resident C's clinical record, treatment orders, and care plan with the attending physician. **c.** On 5/26/2021, the DON reviewed resident D's clinical record and treatment orders, and care plan with the attending physician. Treatment orders for the outpatient wound care clinic were clarified. **B) How will you identify other residents having the potential to be affected by the same practice, and what corrective actions will be taken?** **a.** On 5/26/2021 the DON/Designee conducted an audit of physician orders and clinical documentation for current residents requiring wound care to ensure compliance with the components of federal regulation F686. There were no other residents identified as having been affected by the alleged deficient practice. **b.** On 5/26/2021 The DON/Designee completed wound	

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	"Sodium Hypochlorite [generic term for Dakin's] solution...Apply to ischial/sacral wounds topically every 12 hours for wound treatment...." Start date of 3/13/21 at 8:00 a.m. and discontinuation date of 3/15/21. The ETAR indicated only 2 out of the 5 possible administrations were completed for the above order. A wound progress note, dated 3/17/21, indicated an initial assessment was conducted of Resident B's wounds by Nurse Practitioner (NP) 2. The following was noted regarding Resident B's wounds: Stage 4 pressure ulcer to right gluteus with measurements and description of wound, Stage 4 pressure ulcer to left trochanter (where the femur joins the hip bone) with measurements and description of wound, Stage 4 pressure ulcer to right, lateral upper leg with measurements and description of wound, Stage 4 pressure ulcer to sacrum with measurements and description of wound, & Stage 4 pressure ulcer to left ischium (lower and back part of the hip bone) with measurements and description of wound. The wound note, dated 3/17/21, by NP 2 indicated the plan to apply collagen to wound bed, cover with abdominal pad, and secure with tape. This was to be changed every 3 days and as needed. This order applied to Resident B's right/lateral upper leg, sacrum, and left ischium. A wound VAC was to be applied to the right gluteus and left trochanter with a Vac drape to the surrounding skin of the wound with black foam and be changed every 3 days and as needed.		care observations to ensure compliance with the components of federal regulation F686. There were no other residents identified as having been affected by the alleged deficient practice. **C) What Measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur?** **a.** On 5/28/2021 the DON/designee completed staff re-education regarding; measuring and describing wounds on newly admitted residents with corresponding treatment orders, wound care documentation and routine skin checks, documentation treatment administration in the electronic health record, and following physician orders with emphasis on the components of federal regulation F686. **D) How will the corrective actions be monitored to ensure the practice will no reoccur; what Quality measures will be put into place?** **a.** DON/Designee will conduct random audits of new admission documentation to ensure compliance with federal regulation F686 weekly x4, then monthly for 90 days or until substantial compliance is achieved. **b.** DON/Designee will conduct random audits of wound	

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	There was no previous order for a wound VAC for Resident B from admission, 3/12/21, until 3/17/21. A physician order, start date of 3/17/21, indicated the following, "...Left and right hip: cleanse areas with NS [normal saline]. Apply collagen to wound bed. Apply wound vac...." The wound vac was scheduled to be changed on Monday, Wednesday and Friday's. This order didn't mirror the plan in NP 2's wound notes specific to the use of collagen for the wound vac dressing. A physician order, start date of 3/17/21, indicated the following, "...Sacrum, left groin, and right thigh: cleanse areas with NS. Pat dry. Apply collagen to wound bed and cover with foam dressing and/or ABD pad secure...." The treatment was scheduled to be completed on Monday, Wednesday, and Friday's. The order did not mirror the plan in NP 2's wound notes specific to the frequency of the order being every 3 days and the location of the left groin instead of the left ischium. A wound progress note, dated 3/24/21, indicated a change in treatment to Resident B's wounds. The following was noted: Cleanse with 1/4 strength Dakin's solution, pat dry, apply 1/4 strength Dakin's-soaked gauze to wound bed and cover with abdominal pad and secure with tape twice daily. This order applied to the left trochanter, sacrum, and left ischium. Cleanse with normal saline, pat dry, apply collagen to wound bed and cover with abdominal pad and secure with tape every 3 days and as needed. This order applied to the right/lateral		documentation and treatment orders to ensure compliance with federal regulation F686 weekly x4, then monthly for 90 days until substantial compliance is achieved. **c.** Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined.	

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	upper leg. Wound vac with pressure setting of 125 mm/hg (millimeters of mercury) to the right gluteus. A physician order, start date of 3/27/21, indicated the following, "...Dakins...Apply to sacrum and left ischial topically every day shift...." This order was not initiated for 3 days after Resident B was seen by NP 2 on 3/24/21 and didn't reflect the need to be changed twice a day. A physician order, start date of 3/29/21, indicated the following, "...Right hip: cleanse areas with NS. Apply collagen to wound bed. Apply wound vac and connect areas with Y-port and 200 mmHg...." This order didn't mirror the plan in NP 2's wound notes for the application of collagen to the wound bed or the setting of 200 mm/hg instead of 125 mm/hg as noted on the 3/24/21 wound note. A physician order, start date of 3/27/21, indicated the following, "...Right upper thigh: cleanse area with NS. Apply collagen to wound bed and cover with dry dressing daily...." This order didn't mirror the plan in NP 2's wound notes for the frequency of being change every 3 days and as needed. A pressure ulcer care plan, target date of 4/6/21, indicated the following, "...The resident has pressure ulcer l/r [sic] hip thigh [sic], left groin, right thigh, sacrum...Interventions...Administer treatments as ordered...Apply wound vac per orders...Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate...."			

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	An interview conducted with the Director of Nursing (DON), on 5/12/21 at 5:43 p.m., indicated she expects staff to conduct a head-to-toe assessment upon admission that includes documentation of the presence of wounds. She doesn't necessarily call for the nursing staff to stage the wounds but to identify any wound present upon admission. 2. The clinical record for Resident C was reviewed on 5/12/21 at 3:28 p.m. The diagnoses included, but were not limited to, nontraumatic cerebral hemorrhage, cerebral infarction, muscle weakness, pressure ulcer, and pressure-induced deep tissue damage of left and right heel. Resident C was admitted to the facility on 4/7/21 and hospitalized on 4/30/21 and readmitted to the facility on 5/10/21. An admission assessment, dated 4/7/21, indicated Resident C's skin integrity was documented as "bilateral heels and sacrum" under skin impairments but no descriptions and/or measurements of the skin impairments noted in Resident C's clinical record upon admission. A care plan, initiated on 4/8/21, indicated the following, "...The resident has pressure ulcer to sacrum, bilateral heels...Interventions...Administer treatments as ordered...Assess/record/monitor wound healing per orders. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress...Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate...."			

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	A "Weekly Summary with Weekly Skin Check" document, dated 4/19/21, indicated the following, "...sacrum 0.5 x 0.7 x 0.5...." There was no description or further assessment of the wound. A wound progress note, dated 4/21/21, indicated a stage 4 pressure ulcer to Resident C's coccyx with assessment and measurements with description noted. Resident C was hospitalized on 4/30/21 and readmitted on 5/10/21. A readmission assessment, dated 5/10/21, noted an open area to the sacrum but no description and/or measurements were documented. 3. The clinical record for Resident D was reviewed on 5/12/21 at 3:46 p.m. The diagnoses included, but were not limited to, muscle weakness, cutaneous abscess of left foot, and cellulitis. Resident D was admitted to the facility on 4/12/21. An admission assessment, dated 4/12/21, indicated the following, "...Description...Right posterior ankle: noted to be a DTI [deep tissue injury]...Impaired area inner ankle. Noted to be vascular...Resident is seen weekly by [name of hospital] wound care clinic where tx [treatment] are completely [sic]. Will request wound care notes...." There was no description and/or measurements of the wounds listed for Resident D. A "Weekly Skin Check", dated 4/19/21, noted left ankle with current skin/wound treatments. No measurements or description of the wound noted.			

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A "Weekly Skin Check", dated 4/26/21, noted left ankle with current skin/wound treatments. No measurements or description of the wound noted.

A "Weekly Skin Check", dated 5/3/21, noted abdominal folds and left lower extremity with current skin/wound treatments. No measurements or description of the wound noted.

A wound progress note, dated 5/7/21, indicated a vascular wound to Resident D's right, posterior Achilles.

There were no physician orders for treatments from 4/12/21 until 5/10/21.

A physician order, start date of 5/10/21, indicated the following, "...LLE [left lower extremity]: Cleanse toe to knee with soap and water. Pat dry. Wrap toe to knee with Coban 2 layer compression system. every day shift every Mon, Fri [Monday and Friday] for wound care...."

A physician order, start date of 5/10/21, indicated the following, "...RLE [right lower extremity]: Cleanse with soap and water. Pat dry. Apply collagen/medifill [sic] to open area. Wrap toe to knee with tubigrip and apply compression sleeve. every day shift every Mon, Fri [Monday and Friday] for wound care...."

An interview conducted with the DON, on 5/12/21 at 5:43 p.m., indicated Resident D went to the wound clinic and they did all of his treatments there. That's why there appears to be no order until recently. We were having a difficult time obtaining the records from the

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	wound clinic. So, we started having the wound NP follow him here and orders initiated for us to complete. A policy titled "Pressure Ulcers/Skin Breakdown - Clinical Protocol", revised April of 2018, was provided by the Executive Director on 5/12/21 at 5:13 p.m. The policy indicated the following, "...1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers...2. In addition, the nurse shall describe and document/report the following...a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue...3. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions...Treatment/Management...1. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings [occlusive, absorptive, etc.], and application of topical agents...Monitoring...1. During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly-healing wounds...." This Federal tag relates to Complaint IN00351583. 3.1-40(a)(2)			