| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155271 | A. BUILDING 00<br>B. WING | 04/12/2023 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00404639, IN00398885, IN00392443.<br><br>Complaint IN00404639 - Federal/State deficiencies related to the allegations are cited at F921.<br><br>Complaint IN00398885 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00392443 - No deficiencies related to the allegations are cited.<br><br>Unrelated deficiencies are cited.<br><br>Survey dates: April 10, 11, and 12, 2023<br><br>Facility number: 000171<br>Provider number: 155271<br>AIM number: 100267050<br><br>Census bed type:<br>SNF: 14<br>SNF/NF: 46<br>Total: 60<br><br>Census payor type:<br>Medicare: 6<br>Medicaid: 48<br>Other: 6<br>Total: 60<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on April 17, 2023 | F 0000 | Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is May 3, 2023.<br><br>Facility is respectfully requesting paper compliance for all deficiencies in this POC. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Chris Peter | Administrator | 04/26/2023 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0842<br>SS=D<br>Bldg. 00 | 483.20(f)(5), 483.70(i)(1)-(5)<br>Resident Records - Identifiable Information<br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records,<br>regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral | | | |

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| | directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. | | | |
| | Based on observation, interview and record review, the facility failed to ensure complete and accurate documentation of a resident's clinical record for 1 of 1 resident randomly reviewed for personal property. (Resident L)<br><br>Findings include:<br><br>The clinical record for Resident L was reviewed on 4/11/23 at 10:40 a.m. Her diagnoses included, but | F 0842 | Resident L's inventory sheet was completed, all items accounted for, including missing shoulder purse with contents, 4/21/23.<br>All residents had the potential to be affected by the alleged deficient practice. All resident charts were audited for Inventory Sheet completion, and any concerns | 05/03/2023 |

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| | were not limited to, major depressive disorder. She was admitted to the facility on 4/5/23 from another facility.<br><br>The 4/11/23 progress note for Resident L, written by the Activities Director, indicated Resident L informed her that her purse was missing.<br><br>An interview and observation was conducted with Resident L in her room on 4/11/23 at 10:45 a.m. She indicated someone took her wallet that contained her debit card and social security card. It was brown with zippers and a shoulder strap. She subsequently canceled her debit card and contacted social security about getting a new social security card. She last saw the wallet on 4/9/23 and suspected it was taken while she was in the shower on 4/10/23. She did not fill out an inventory sheet upon admission to the facility, as they did not provide one for completion until a couple days after admission and needed help to complete it. There was a blank, unsigned inventory sheet folded in half on Resident L's bedside table at this time.<br><br>An interview was conducted with the DON (Director of Nursing) on 4/11/23 at 12:46 p.m. She indicated inventory sheets should be completed the day of admission, so all personal belongings could be accounted for.<br><br>The DON provided a copy of a blank inventory sheet on 4/12/23 at 12:10 p.m. It had a section for non-clothing items including a purse/wallet. There was a section at the bottom for the resident or responsible party to sign and date as well as a staff member on admission.<br><br>The DON provided the Resident Personal Clothes and Belongings Handling policy on 4/11/23 at 3:13 | | identified were addressed, 4/19/23.<br>Nursing staff will be re-educated by the Inservice Director by 4/28/23 on the facility policy and procedure “Resident Personal Clothing and Belongings Handling”. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated.<br><br>*Director of Nursing or designee will audit new resident Inventory Sheets 3 times a week for 4 weeks, 2 times a week for 4 weeks, 1 time per week for 4 months. The monitoring will take place for no less than 6 months. If the facility is within 100% compliance at the end of the 6 months monitoring will be stopped.* Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. | |

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| | p.m. It read, "Purpose: To ensure that all clothing/personal belongings are identified/labeled/stored/laundered appropriately. Procedure: (Upon admission and annually the following will be done...) Personal belongings are to be listed as well, such as TV/Recliner/bookcase etc....The CNA [Certified Nursing Assistant] submits the list of the resident's clothing/belongings to the charge nurse. This list becomes part of the chart. The CNA will inform the nurse as new articles of clothing/belongings are brought in or removed so that the inventory sheet can be updated. Items brought in will be labeled appropriately."<br><br>3.1-50(a)(1) | | | |
| F 0921 SS=D Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation, interview, and record review, the facility failed to ensure residents' rooms were maintained in a cleanly manner regarding floor care for 2 of 5 residents reviewed for room cleanliness. (Residents B and K)<br><br>Findings include:<br><br>1. The clinical record for Resident B was reviewed on 4/10/23 at 11:24 a.m. Her diagnoses included, but were not limited to, Covid-19, dementia, and Parkinson's disease. She was admitted to the facility on 3/8/23 after a hospitalization for worsening symptoms of Covid-19. She was discharged from the facility to home on 3/24/23.<br><br>An interview was conducted with Family Member | F 0921 | Resident K's room was thoroughly cleaned on 4/12/23, Resident B was discharged on 3/24/23.<br>All residents had the potential to be affected by the alleged deficient practice. All resident rooms were audited and any issues identified were addressed immediately. Audit completed on 4/26/23.<br>All Housekeeping staff were re-educated by the V.P. of Property Management and Director of Environmental Services on the Environmental General Cleaning Policies-Resident Rooms on 4/26/23. Additionally, any | 05/03/2023 |

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| | 2 on 4/11/23 at 11:59 a.m. She indicated Resident B was in transmission based precautions for Covid-19 the whole time she was at the facility. She visited twice a day and everyday she visited, the same trash was on the floor and under the bed. She asked staff about sweeping the room, but the following day, the same trash remained on the floor, so she retrieved a broom and swept the room herself.<br><br>An interview was conducted with the HS (Housekeeping Supervisor) on 4/11/23 at 10:45 a.m. She indicated they didn't currently have any residents in transmission based precaution rooms, but most recently, Resident B resided in one. At the time, housekeeping did not clean transmission based precaution rooms daily, only upon request. Resident B's family requested her room be cleaned, so housekeeping obliged, but that was day 3 of her stay. The room was not cleaned by housekeeping her first 2 days at the facility. They relied on nursing to clean the room as needed. The HS was more recently informed transmission based precaution rooms needed cleaned daily.<br><br>An interview was conducted with LPN (Licensed Practical Nurse) 3 on 4/11/23 at 11:46 a.m. She indicated when a resident was in transmission based precautions, nursing would wipe down frequently touched items like the bedside table and bed rails, but did not sweep or mop the floors. She knew housekeeping was having some staffing issues.<br><br>2. The clinical record for Resident K was reviewed on 4/12/23 at 9:40 a.m. Her diagnoses included, but were not limited to, heart failure.<br><br>The 12/12/22 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief | | employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated<br><br>Housekeeping Director or designee will audit no less than 5 random resident rooms 3 times per week for 4 weeks, 2 times a week for 4 weeks, 1 time per week for 4 months. The monitoring will take place for no less than 6 months. If the facility is within 100% compliance at the end of the 6 months monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. | |

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| | interview for mental status) score of 13, indicating she was cognitively intact.<br><br>An interview and observation was conducted with Resident K in her room on 4/12/23 at 10:00 a.m. There was a significant amount of crumbs, debris, and food particles all over her floor, in the corner near her walker, on both sides of the recliner in which she was sitting, in the middle of the floor, and around her bed. Resident K indicated staff did not clean the floors regularly and it had been about 2 weeks since it was last swept and mopped. She would like for them to clean it more often.<br><br>On 4/12/23 at 10:15 a.m., an interview was conducted with the HS (Housekeeping Supervisor) on the way to observe Resident K's room with her. The HS indicated one of the housekeepers was supposed to clean Resident K's room yesterday, and as far as she knew, it had been, but housekeeping staff were not currently required to document or sign off on cleaning of residents' rooms. The housekeeping department was currently down 3 staff members.<br><br>An observation of Resident K's room was made with the HS on 4/12/23 at 10:17 a.m. The crumbs, debris, and food particles remained. The HS indicated it looked to her like the floors needed to be cleaned. Resident K informed the HS that no one came in and cleaned the floors yesterday.<br><br>The General Cleaning Policies and Procedures Resident Room - Clean was provided by the RDO (Regional Director of Operations) on 4/11/23 at 2:37 p.m. It read, " Purpose: To provide a clean, attractive and safe environment for residents, visitors and staff....Materials required: ...3. "Wet Floor" Caution Signs...16. Endless Twist Hospital | | | |

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| | Dust Mops 17. Dust Mop Holder 18. Broom."<br><br>This Federal tag relates to Complaint IN00404639.<br><br>3.1-19(f)(5) | | | |