STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	01/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN0041942 and IN00426071. Complaint IN00419427 -- Federal/state deficiency related to the allegations is cited at F641. Complaint IN00426071 -- No deficiencies related to the allegations are cited. Survey date: January 25, 2024 Facility number: 000171 Provider number: 155271 AIM number: 100267050 Census Bed Type: SNF/NF: 32 SNF: 14 Total: 46 Census Payor Type: Medicare: 2 Medicaid: 23 Other: 21 Total: 46 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 29, 2023	F 0000		
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility	F 0641	**F 641 -**	02/11/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Thompson	Administrator	02/08/2024

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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	failed to ensure a Minimum Data Set (MDS) assessment was correctly completed, related to falls for 1 of 3 residents reviewed for falls. (Resident B) Findings include: The clinical record of Resident B was reviewed on 1-25-24 at 12:12 p.m. It indicated she was admitted to the facility on 10-2-23, with diagnoses that included, but were not limited to, unspecified encephalopathy, diabetes, rheumatoid arthritis, depression, high blood pressure, unspecified signs and symptoms of cognitive function, general muscle weakness and unspecified protein-calorie malnutrition. Her admission MDS assessment, dated 10-9-23, under section J, indicated the facility was unable to determine if she had any falls or fractures in the 6 month period prior to her admission to the facility. It indicated she had sustained no falls from the time of her admission through the assessment reference date (ARD) of 10-9-23. A review of the clinical record from the date of admission and through 10-9-23, indicated she had sustained two falls on 10-8-23, one at 2:00 a.m. and the second at 5:30 p.m. In an interview on 1-25-24 at 2:00 p.m., with the Corporate Nurse, she indicated around the date of the MDS assessment for Resident B, the regular MDS staff person was out on medical leave and the facility was using a corporate MDS person. During the exit conference on 1-25-24 at 3:40 p.m., the Corporate Nurse indicated it appeared the regular MDS staff had conducted this particular MDS assessment.		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 (Date of Compliance) Facility is respectfully requesting paper compliance for all deficiencies in this POC. We are respectfully asking for paper compliance. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** Resident B, MDS dated 10/09/2023 was corrected on 01/30/2024 to indicate resident had a fall since admission. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents that have falls that currently reside in the facility have the potential to be affected by the alleged deficient practice. The MDS Coordinator or designee completed a facility wide audit by	

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	In an interview on 1-25-24 at 3:30 p.m., with the Executive Director, he indicated the facility does not have a particular policy related to the MDS assessments, but utilizes the most current RAI (Resident Assessment Instrument) manual. The Centers for Medicare & Medicaid Services ' Long-Term Care Facility Resident Assessment Instrument (RAI) User ' s Manual, October 2023, For Use Effective October 1, 2023, Section J, indicates for the review period for falls for the first or admission assessment, "review the medical record for the time period from the admission date to the ARD...Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment. All relevant records received from acute and post-acute facilities where the resident was admitted during the look-back period should be reviewed for evidence of one or more falls. Review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury. Ask the resident, staff, and family about falls during the look-back period. Resident and family reports of falls should be captured here, whether or not these incidents are documented in the medical record. Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results), and ensure that this information is used to code the assessment." This Federal deficiency relates to Complaint IN00419429. 3.1-31(a)		02/06/2024 on residents who have fallen in the last 90 days to verify MDS Accuracy. Any inaccurate MDS assessments related to falls were corrected. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** MDS Consultant or designee completed education with MDS Coordinator on 2/5/2024 related to accuracy of MDS assessments. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. The MDS coordinator or designee will complete and MDS accuracy audit related to falls. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place** *MDS Nurse or designee will audit MDS's once weekly for accuracy related to falls x 6 months.* If the facility is within 95% compliance at the end of the 6 months; then monitoring can 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	

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			by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **By what date the systemic changes for each deficient will be completed.** February 11, 2024	