STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155271		A. BUILDING B. WING		COMPI	(X3) DATE SURVEY COMPLETED 10/08/2024	
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, T	8400	ET ADDRESS, CITY, STATE, ZIP COD O CLEARVISTA PL ANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE
F 0000						
Bldg. 00	Licensure Survey. Investigation of Co IN00433065, IN00 Complaint IN0042 related to the allegated to the allegations are Complaint IN0043 the allegations are Complaint IN0044 the allegations are Survey dates: Octo Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type Medicare: 1 Medicaid: 39 Other: 9 Total: 49	2971 - No deficiencies related to cited. sber 2, 3, 4, 7, and 8, 2024 00171 155271 267050 e: reflect State Findings cited in	F 0000	F000 Preparation and/or execution this plan of correction in gen or this corrective action does constitute an admission of agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of corrand specific corrective action prepared and/or executed in compliance with State and F Laws. Facility's date of alleg compliance is October 26, 2 Facility is respectfully reques paper compliance for all deficiencies in this POC.	eral, s not the set rection ns are federal ed 024.	

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

(X6) DATE

TITLE

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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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		155271	B. W	ING		10/08/2024	
	PROVIDER OR SUPPLIE			8400 C	ADDRESS, CITY, STATE, ZIP COD		
WATER	S OF CASTLETON	SKILLED NURSING FACILITY, 1	HE	INDIAN	NAPOLIS, 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 APPROPRIAT	TE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	Quality review con	npleted on October 9, 2024.					
F 0550 SS=D	483.10(a)(1)(2)(b) Resident Rights/E						
Bldg. 00							
	D 1 1		F 0	550	F550	10/26/2024	
		on, interview, and record			It is the policy of the facility to		
		failed to ensure a resident's			ensure the residents dignity is		
		ined by not sitting down while with eating for 1 of 1 resident			maintained and staff sit while		
	_	during dining. (Resident 2)			assisting residents with eating.		
	randomly observed	during dining. (Resident 2)			What corrective action will be	e	
	Findings include:				accomplished for those residents found to have been		
	rindings include.					·	
	The clinical record	for Resident 2 was reviewed on			affected by the deficient practice;		
		m. The diagnoses included, but			The SSD/Designee assessed		
	were not limited to	_			Resident # 2, no negative		
	Were not immed to	, demendia.			psychosocial side effects noted	d	
	A Ouarterly Minim	um Data Set (MDS)			from this alleged deficient		
		7/10/24, indicated cognitive			practice.		
	impairment.	,			How other residents having t	the	
					potential to be affected by the		
	An Activities of Da	aily Living (ADL) care plan,			same deficient practice will b		
	revised 12/22/23, in	ndicated she needed assistance			identified and what corrective	e	
	with eating.				action will be taken.		
					All residents have the potentia	ıl to	
	An observation was	s conducted of Resident 2 in			be affected by the cited practic	ce,	
	_	10/7/24 at 12:35 p.m. The			therefore, this plan of correctio	on	
		ved sitting at a table in the			applies to all residents that res	ide	
	_	fied Nursing Assistant (CNA) 1			in the facility.		
		o the resident's table assisting			What measures will be put in	i l	
	the resident with ea	iting her meal.			place and what systemic		
		1 4 1 24 4 57			changes will be made to		
		conducted with the Nurse			ensure that the deficient		
		n 10/7/24 at 3:30 p.m. She			practice does not recur.		
		nould have been sitting while			The Director of Nursing or		
	assisting Resident 2	with ner meal.			designee completed education		
		1' '1 11 4 370			with nursing staff on to sit until		
	A resident rights po	olicy was provided by the NC			assisting residents with meals	to	

on 10/8/24 at 10:14 a.m. It indicated, "...7) It is

maintain dignity. Additionally, any

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155271	B. W	ING		10/08/	2024
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			LEARVISTA PL		
\\/\TED	COE CASTI ETON	SKILLED NURSING FACILITY, TI	JC		IAPOLIS, IN 46256		
WATER	OF CASTLETON	SKILLED NORSING FACILITY, TI	<u> </u>	INDIAN	AFOLIS, IN 40230		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	important that staff	be aware of the resident rights			employee who fails to comply	with	
	to include, but not	limited toA dignified			the points of the in-service ma	y be	
	existence - resident	being treated with dignity in			further educated and/or		
	all situationsTo a	chieve thisstaff will1) Treat			progressively disciplined as		
	each resident with	respect and dignity. 2) Care for			indicated.		
	each resident in a n	nanner and environment that					
	promotes the maint	enance of/or enhances the			How the corrective action wi	II	
	resident's quality of	f life"			be monitored to ensure the		
					deficient practice will not		
	3.1-3(t)				recur, i.e what quality		
					assurance program will be p	ut	
					into place:		
					Feeding QA Audit Form will be		
					completed on 10 random resid	dents	
					during random meal services		
					weekly x 4 weeks, 5 random		
					residents weekly x4 weeks, ar		
					then 3 random resident month	-	
					4 months. If the facility is with		
					95% compliance at the end of		
					6 months; then monitoring car		
					stopped. Results of the monitor	_	
					will be reviewed at the monthl	-	
					QAPI meeting. Any concerns		
					have been addressed. Howev		
					any patterns will be identified.	Any	
					needed Action Plan will be wr	tten	
					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 w	/ill	
					be completed. 10/26/2024		
F 0565	483.10(f)(5)(i)-(iv)						
SS=D	Resident/Family (Group and Response					
Bldg. 00							
			F 0	565	F565		10/26/2024
	Based on interview	and record review, the facility			It is the policy of this facility to		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/08/2024 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 failed to timely address a resident's grievance for 1 address grievances timely. of 1 resident reviewed for choices. (Resident 11) what corrective action(s) will be accomplished for those Findings include: residents found to have been affected by the deficient The clinical record for Resident 11 was reviewed practice; on 10/3/24 at 9:00 a.m. The diagnoses included, but were not limited to, stroke. Resident 11 grievance was resolved to resident's satisfaction A quarterly Minimum Data Set (MDS) by the ADM/Designee on Assessment, dated 9/12/24, indicated Resident 11 10/7/2024 was cognitively intact. An interview was conducted with Resident 11 on how other residents 10/3/24 at 9:41 a.m. He indicated he had been having the potential to be storing a Tupperware container that contained his affected by the same deficient tea pot and tea bags in a cabinet in the dining practice will be identified and room for years. He was told a couple of days ago; what corrective action(s) will he no longer was allowed to do that anymore. He be taken; had to store the Tupperware container in his room and take it back-an-forth from his room to the The Administrator/Designee dining room every meal. It made it difficult. He was completed a 90 day look back of never given a reason why he could no longer grievances for follow up/resolution store the container in the dining room. The with resident on 10/23/2024. resident had told everyone he was not happy about it. He had worked really hard to be able to what measures will be use his crutches, but now he had to get back in put into place and what the wheelchair. He cannot take his Tupperware systemic changes will be made container to the dining room with his crutches. to ensure that the deficient practice does not recur; An interview was conducted with the Activities Director on 10/7/24 at 2:49 p.m. She indicated The Social Service Resident 11 was unhappy he was unable to store Director/designee completed

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his teapot and tea bags in the dining room. He had

10/1/24, he was no longer able to store it there. He

back-an-forth to the dining room. She did not fill

stored the Tupperware container in the dining

room for years, but was told, either 9/30/24 or

would use an exercise band strapped to his

wheelchair to take his Tupperware container

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with the points of the in-service

education with all staff on

10/23/2024 related to grievance

policy. Resident will be educated

of grievance policy during resident

council on 10/25/24. Additionally,

any employee who fails to comply

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/08/2024 155271 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8400 CLEARVISTA PL INDIANAPOLIS, IN 46256 WATERS OF CASTLETON SKILLED NURSING FACILITY, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE out a grievance form about the resident's concern. may be further educated and/or progressively disciplined as A grievance policy was provided by the indicated. Administrator on 10/8/24 at 10:24 a.m. It indicated, "... Purpose: To provide a 'process' by which a how the corrective resident or resident's representative can have their action(s) will be monitored to questions/concerns brought to the proper source ensure the deficient practice to be answered/addressed and resolved as much will not recur, i.e., what quality as possible to the satisfaction of the resident or assurance program will be put their representative and to have this activity into place. documented including: A. Question and Details B. The SSD/Designee will interview Action taken (and by whom) C. Dates/Times D. 10 random residents weekly x 4 Response back to resident/representative E. weeks, then 5 random residents Documentation complete F. Filing in 'I would Like weekly x weeks, then 3 random to know'... binder. Procedure: 1. When a resident residents weekly x 4 weeks, then or a resident's representative presents a 3 random residents monthly x 3 question/concern, a staff member obtains the 'I months for any concerns and a would like to know'... form. A staff member grievance form will be completed completes the form for the resident or the and follow up/resolution will be resident's representative. If possible, a leadership completed by appropriate staff person should complete the form. The form is department. then deposited into a designated secure area...3. The Administrator/Designee will During the following morning meeting, the audit grievances for follow Administrator or designee reads the 'I would like up/resolutions and resident to know'... form to the CQI [Continuous Quality notification weekly x 4 weeks, Improvement] committee and logs the then 3 times a week x 4 weeks, questions/concern on the tracking form. 4. The then once a week x 4 weeks. then Department Head(s) who is designated by the once a month x 3 months. If the Administrator/CQI Committee to be the facility is within 95% compliance appropriate person(s) to address the at the end of the 6 months; then question/concern will be provided a copy of the 'I monitoring can be stopped. would like to know form' ... 6. At the CQI meeting, Results of the monitoring will be the Administrator or designee will review the log reviewed at the monthly QAPI and the status of the unanswered meeting. Any concerns will have questions/concerns will be discussed. The been addressed. However, any objective being to answer all logged patterns will be identified. Any

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questions/concerns as soon as possible. 7. The

share what has been done to date to

assigned Department Head should be prepared to

answer/resolve the question/concern...10. When

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needed Action Plan will be written

by the QAPI committee. Any

monitored by the Administrator

written Action Plan will be

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						•	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLI	ETED
		155271	B. WI	NG		10/08/2	2024
NAME OF P	ROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD		
\\\\ TED		01/11 ED 111 DOING E1 011 TV T			LEARVISTA PL		
WATERS	OF CASILETON S	SKILLED NURSING FACILITY, T	HE	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	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	416	DATE
	the question/concern	n has been answered or has			weekly until resolved.		
	•	greatest degree possible, the			by what date the syste	mic	
		nt Head will contact the			changes for each deficiency		
		discuss what has been done.			will be completed. October 2		
		the resident or the resident's			2024	20,	
	-	rstands and agrees with or			2024		
	accepts the 'answer'	_					
	satisfaction"	as being to then					
	Sausiacuoii						
	2.1.7(a)(2)						
	3.1-7(a)(2)						
	3.1-7(b)						
F 0641	492 20(a)						
SS=B	483.20(g)	amonto					
Bldg. 00	Accuracy of Asses	ssments					
Diug. 00			FO	- 11	F641		10/26/2024
	Dagad an interview	and manad marriage, the facility	F 06	041			10/26/2024
		and record review, the facility			It is the policy of this facility to		
	_	code the Minimum Data Set			ensure the MDS assessment	IS	
	` '	for 4 of 7 residents reviewed			coded accurately.		
	for MDS accuracy ((Resident 1, 12, 22, and 42).			What corrective action will be	oe	
	TO 11 1 1 1				accomplished for those		
	Findings include:				residents found to have bee	n	
					affected by the deficient		
		rd for Resident 1 was reviewed			practice:		
		p.m. The diagnoses included,			Resident #1 MDS dated		
	but were not limited	l to, paraplegia.			08/18/2024 was corrected on		
					10/07/2024 to indicate no		
	The Admission MD	S assessment, dated 8/18/24,			restraints, by the MDS		
	indicated Resident 1	l had bed rails used as a			Nurse/Designee.		
	restraint daily.				Resident #12 MDS dated		
					09/13/2024 was correct on		
	2. The clinical recor	rd for Resident 12 was reviewed			10/07/2024 to indicate no		
	on 10/7/24 at 12:40	p.m. The diagnoses included,			restraints by the MDS		
	but were not limited	-			Nurse/Designee.		
					Resident #22 MDS dated		
	The Quarterly MDS	S assessment, dated 9/13/24,			08/31/2024 was corrected on		
	-	12 had bed rails used as a			10/07/2024 to indicate no		
	restraint daily.				restraints by the MDS		
					Nurse/Designee.		
	3 The clinical ross	ord for Resident 22 was			Resident #42 MDS dated		
	j. The chilical reco	na ioi kesiaein 22 was	1		I MESIUEIII #42 IVIDO UBIEO		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155271	B. W	ING		10/08/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			LEARVISTA PL		
WATERS	S 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	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		4 at 12:48 p.m. The diagnoses			09/11/2024 was corrected on		
	included, but were	not limited to, hypertension.			10/7/2024 to indicate no restra	aints	
					by the MDS Nurse/Designee.		
		S assessment, dated 8/31/24,			How other residents having		
		22 had bed rails used as a			potential to be affected by th		
	resident daily.				same deficient practice will b		
					identified and what correctiv	е	
		ord for Resident 42 was			action will be taken.		
		4 at 12:55 p.m. The diagnoses			The MDS Coordinator/designe	ee	
	included, but were	not limited to, depression.			completed a 90-day lookback		
					10/23/24 on residents who ha		
		OS assessment, dated 9/11/24,			siderails to verify MDS accura	-	
		42 had bed rails used as a			any incorrect coding was mod	ified	
	restraint daily.				on 10/24/2024.		
	l				What measures will be put ir	l	
	-	w on 10/7/24 at 2:38 p.m., the			place and what systemic		
		Coordinator (MDSC) indicated			changes will be made to		
		sments had been coded			ensure that the deficient		
		e bed rails used were enables			practice does not recur.		
	for bed mobility, no	ot as restraints.			MDS Consultant/designee	_	
		10/7/04 + 2.40			completed education with MD		
	-	w on 10/7/24 at 2:40 p.m., The			Coordinator on 10/23/24 relate		
		idicated the facility used the			accuracy of MDS assessment		
		ent Instrument (RAI) Manual			Additionally, any employee wh		
	as the policy.				fails to comply with the points	OT	
					the in-service may be further		
					educated and/or progressively	1	
					disciplined as indicated. How the corrective action wi		
					be monitored to ensure the		
					deficient practice will not		
					recur, i.e what quality		
					assurance program will be p	ut	
					into place The DON/Designee will audit		
					residents MDS assessment fo	r	
					accurate coding related to be		
					rails weekly x 6 months. If the	,	
					·	ofter	
					facility is within 9% complaint		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 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 10/08/2024 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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. By what date the systemic changes for each deficient will be completed. 10/26/2024 F 0684 483.25 SS=E Quality of Care Bldq. 00 F684 F 0684 10/26/2024 Based on observation, interview, and record It is the policy of the facility to review, the facility failed to administer medications administer medications, collect and collect urine samples as ordered, to timely urine samples, schedule follow up schedule a follow-up appointment for a resident appointments, implement dietary who was admitted with a healing leg fracture, and recommendations for residents timely implement dietary recommendations for a with tube feeding timely.

Findings include:

1. The clinical record for Resident 42 was reviewed on 10/3/24 at 1:18 p.m. The diagnoses included, but were not limited to, fracture of the lower femur (thighbone) and depression. She was admitted to the facility on 9/4/24.

resident with a feeding tube for 1 of 1 resident

feeding tubes, and 3 of 5 residents reviewed for

unnecessary medications. (Resident 11, Resident

29, Resident 30, Resident 42, and Resident 95)

reviewed for mobility, 1 of 1 resident reviewed for

Resident #42 had follow up orthopedic appointment scheduled for 10/10/2024. This appointment was cancelled by resident #42 son and is now rescheduled for

what corrective action(s)

will be accomplished for those

residents found to have been

affected by the deficient

10/28/2024, the DON/Designee. Resident #30 had order placed in EHR on 10/17/2024 for weekly

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practice;

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155271	B. WI	ING		10/08/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			LEARVISTA PL		
\\\\ATEDQ	S OF CASTLETON	SKILLED NURSING FACILITY, TH	F		APOLIS, IN 46256		
VVATERS	O CASILETON	ONLEED NONGING FACILITY, IT	_	INDIAN	AI OLIO, IIN 40200		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ess note, dated 9/10/24,			weights to be obtained per die	tary	
		42 had recently admitted to the			recommendation by the		
		previous stay at another			DON/Designee.		
		ty following a right femur			Resident #11 urine was collec		
	fracture on 7/26/24.				on 09/26/2024. Resident #29		
					new order for Metoprolol Succ	inate	
		imum Data Set (MDS)			ER 50mg daily received on		
		/11/24, indicated Resident 42			10/14/2024 and prn Clonidine		
	· ·	e impairment and was			order was discontinued on		
	•	for bed mobility and lower			10/18/2024, by the		
	body dressing.				DON/Designee.		
	A 1 '' 1 1	1 4 10/17/24 : 1: 4 141			Resident #29 degludec insulin		
		, dated 9/17/24, indicated the			order was updated on 10/14/2		
		to be monitored each shift for			to include parameters on whe		
	-	s. The skin under the brace			hold medication. Resident #29		
		d for open areas, redness,			insulin lispro orders were upda	ated	
	swelling, or any tro	uble moving toes.			on 10/11/2024 to include		
	A1	4-4-10/19/24			parameters on when to hold		
		ss note, dated 9/18/24,			medication by DON/Designee		
		eceived non-surgical care for			Resident #95 urine was collect	ctea	
	-	ture and continued to use a			on 10/18/2024 by the		
		An orthopedic follow-up			DON/Designee.		
	appointment was no	ceucu.			how other residents		
	During an interview	v on 10/3/24 at 2:59 p.m.,					
		Nurse (LPN) 3 indicated			having the potential to be affected by the same deficier	nt .	
		orn the brace on her right leg			practice will be identified and		
		d to the facility and she			what corrective action(s) will		
	_	n orthopedic appointment			be taken;	I	
	coming up soon.	ii ormopeute appointment			o tanen,		
	ap soom				DON/designee completed a 30	0	
	On 10/7/24 at 9:33	a.m., LPN 4 was observed			day look back on 10/23/24 rela		
		e at the nurses' station,			to physician progress notes ar		
		king an appointment for			dietary recommendations to		
		an orthopedic doctor.			confirm all recommendations l	nave	
		1			been completed. DON/Design		
	During an interview	v on 10/7/24 at 9:37 a.m., LPN 4			completed a 30 day look back		
	-	ist made an appointment for			10/23/24 related to physician		
		the orthopedic doctor for a			orders and to confirm urine		
		nent I PN 4 was unsure why			collection orders have been		

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLET	ED
		155271	B. W	ING		10/08/20)24
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
\\\ATED(CKILLED NILIDONIC FACILITY TI			LEARVISTA PL		
WATERS	S OF CASTLETON	SKILLED NURSING FACILITY, TH	16	INDIAN	IAPOLIS, 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)	16	DATE
	the appointment ha	d not been previously			completed. DON/Designee		
	scheduled.				reviewed all current insulin an	d BP	
					medication orders on 10/23/24	1 to	
	During an interview	w on 10/7/24 at 2:14 p.m., the			confirm all orders have hold		
	Director of Nursing	g (DON) indicated the facility			parameters in place per physic	cian	
	should have attemp	ted to make the follow-up			order.		
	orthopedic appoints	ment for Resident 42 sooner.					
	1				what measures will be		
	2. The clinical reco	ord for Resident 30 was			put into place and what		
	reviewed on 10/2/2	4 at 3:25 p.m. The diagnoses			systemic changes will be ma	ıde	
	included, but were	not limited to, epilepsy and			to ensure that the deficient		
	dysphagia (inability	y to swallow).			practice does not recur.		
					ļ ·		
	A care plan, last rev	vised 11/8/23, indicated			/p>		
	Resident 30 had a r	nutritional problem related to					
	having a gastric tub	pe (g-tube) provide all			how the corrective		
	hydration and nutri	tional needs. The goal was for			action(s) will be monitored to	.	
	him to maintain his	weight to within ten percent of			ensure the deficient practice)	
	his ideal body weig	th range. The interventions			will not recur, i.e., what quali	ity	
	included, but were	not limited to, the registered			assurance program will be p	ut	
	dietician to evaluate	e feedings and flushes as			into place;		
	needed for weight of	changes and skin issues. The					
	registered dietician	would make recommendations			The DON/Designee will audit		
	as needed.				Scheduling follow up		
					appointments, following dietar	у	
	_	ht, on 7/9/24, was 188.4 pounds.			recommendations, collecting u		
	His weight, on 8/5/	24, was 193.4 pounds.			samples, and BP medication a		
					Insulin hold parameters audit		
		ssment, dated 8/21/24,			be completed 5 days a week >		
		ed Jevity (type of nutritional			weeks, weekly x 4 weeks, the		
		liter (ml) an hour continuously.			monthly x 4 months. If the faci	-	
	•	on tube feedings for nutrition			is within 95% compliance after		
	_	significant weight gain. The			6 months, the monitoring will b		
	_	e the tube feedings as ordered			stopped. Results of the monitor		
		lowing weights and lower tube			will be reviewed at the monthly	·	
	feeding if weight ga	ain persisted.			QAPI meeting. Any concerns		
					have been addressed. Howev		
	1	eight Assessment Team) note,			any patterns will be identified.	Any	
		cated his most recent weight,			needed Action Plan will be wri	tten	
	done on 8/5/24, wa	s 193.4 pounds. He was to			by the QAPI committee. Any		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155271	B. WI	NG		10/08/	2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L.			_EARVISTA 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	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		tored, and the Registered requested weekly weights.			written Action Plan will be	_	
	Dietician (RD) nad	requested weekly weights.			monitored by the Administrato weekly until resolved.)r	
	A SWAT note date	ed 9/25/24, indicated his most			weekiy unun resorved.		
	·	8/5/24, was 193.4 pounds. The	- hy what date the sys	by what date the systemic			
	_	weekly weight be completed.			changes for each deficiency		
	•				will be completed. 10/26/202		
	A SWAT note, date	ed 10/2/24, indicated his most			·		
		8/5/24, was 193.4 pounds. The					
	_	monthly and weekly weights					
	be completed.						
	7F1 1'' 1 1	1:1					
	September 2024.	did not contain a weight for					
	September 2024.						
	During an interview	on 10/8/24 at 9:30 a.m., Nurse					
	_	ndicated Resident 30's October					
	` ′	s 198.7 pounds. There was not					
	a September weight	-					
	_	on 10/8/24 at 10:49 a.m., NC 1					
	-	eights should have been					
	completed as recom	imended by the RD.					
	O:- 10/9/24 -4 10:40) NC 1					
		a.m., NC 1 provided the Meeting Guidance, dated					
		"Intent: It is the intent of					
	·	s the nutritional status as well					
	=	n status of each resident and					
		ny issues or any potential for					
	issues related to we						
		rentions decided upon by the					
		ed on the individual resident					
	monitoring record f	orm. The appropriate					
		ress interventions determined					
	by the team"						
	_	rd for Resident 11 was reviewed					
	on 10/3/24 at 9:00 a.m. The diagnoses included,						
	but were not limited	l to, stroke.					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED 10/08/2024	
		155271	B. W	_		10/08/	/2024
NAME OF I	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP COD		
\\\\\TEDG	COE CASTI ETON	SKILLED NURSING FACILITY, T	.HE		LEARVISTA PL APOLIS, IN 46256		
	ı		115	<u> </u>	NI OLIO, IIN 40200		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
mo		dated 9/3/24, indicated "Collect		ing			DATE
		are to be picked up on 9/16/24					
	lab day." The start of	date was 9/15/24.					
		dated 9/3/24, indicated "Fax					
		s to Urology of Indianaevery ay dc [discontinue] this order					
	•	The start date was 9/16/24.					
	1						
		4 Medication/Treatment					
		cord indicated, on 9/18/24 and					
	9/19/24, Resident 1	1's urine was not collected.					
	An interview was c	onducted with the Nurse					
		/24 at 3:00 p.m. She indicated					
		was not collected as ordered.					
		rd for Resident 29 was reviewed					
		p.m. The diagnoses included, d to, diabetes mellitus and					
	hypertension.	to, diabetes memus and					
	J1						
	•	n, dated 11/27/23, indicated the					
		eive diabetic medication as					
	ordered.						
	A hypertension care	e plan, dated 11/27/23,					
		vas to administer medications					
	as ordered.						
		1 . 1 4/10/04 2 12 1 4					
		dated 4/10/24, indicated the eive 25 milligrams of metoprolol					
		dication) once daily.					
	(SISSE PIESSUIE IIIC	arrangin, once aming.					
	A physician order,	dated 4/10/24, indicated the					
		eive six units of lispro insulin					
	(fast acting insulin)	with each meal.					
	A physician order	dated 6/27/24, indicated the					
		eive eight units of degludec					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	
		155271	B. WI	NG	_	10/08/	/2024
			'	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			EARVISTA PL		
WATERS	OF CASTLETON	SKILLED NURSING FACILITY, TH	IE		APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE
	insulin (long acting	insulin) twice a day.					
		dated 8/23/24, indicated the					
		eive 0.2 milligrams of clonidine					
	1 -	the systolic blood pressure					
	was greater than 16	0, as needed.					
	The September 202	4 Medication Administration					
	_	t 29 indicated the following:					
	The resident's systo	lic blood pressure was greater					
	than 160, and he did	d not receive the 0.2 milligrams					
	of clonidine on the	following days:					
	0/2/24 blood pro	ssure reading 163/73,					
	_	ssure reading 173/72,					
	_	ssure reading 173/72,					
	_	ressure reading 188/86,					
	_	ressure reading 180/93,					
	_	ressure reading 161/72,					
	_	ressure reading 183/78, and					
	_	ressure reading 167/81,					
		the resident's degludec insulin					
	was not administere	ed as ordered:					
	- 9/4/24 - a.m. dosa	ge,					
	- 9/6/24 - a.m. dosa						
	- 9/7/24 - a.m. dosa						
	- 9/13/24 - a.m. dos	age,					
	- 9/18/24 - a.m. dos	age,					
	- 9/20/24 - a.m. dos	age,					
	- 9/24/24 - a.m. dos	age,					
	- 9/26/24 - a.m. dos	_					
	- 9/30/24 - a.m. dos	age.					
	The following days	the resident's lispro insulin					
	was not administere	-					
	was not administere	ou as sidered.					
	- 9/3/24 - 8:15 a.m.	dosage,					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155271	A. B	MULTIPLE CO UILDING VING	instruction 00	(X3) DATE COMPI 10/08	LETED
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, 1	HE	8400 CL	ADDRESS, CITY, STATE, ZIP COD LEARVISTA PL APOLIS, IN 46256		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIL	DATE
	- 9/4/24 - 8:15 a.m.	dosage,					
	- 9/5/24 - 8:15 a.m.	dosage,					
	- 9/6/24 - 8:15 a.m.	dosage, 12:30 p.m. dosage, 5:30					
	p.m. dosage,						
	- 9/7/24 - 8:15 a.m.	dosage,					
	- 9/9/24 - 8:15 a.m.	_					
	- 9/13/24 - 8:15 a.m						
	- 9/15/24 - 8:15 a.m						
	- 9/16/24 - 8:15 a.m						
	- 9/17/24 - 12:30 p.						
	- 9/18/24 - 8:15 a.m	_					
		n. dosage, 5:30 p.m. dosage,					
	- 9/20/24 - 8:15 a.m	3 /					
	- 9/21/24 - 12:30 p.						
	- 9/22/24 - 8:15 a.m						
	- 9/23/24 - 8:15 a.m	_					
		n. dosage, 5:30 p.m. dosage,					
	- 9/25/24 - 8:15 a.m						
	- 9/26/24 - 8:15 a.m						
	- 9/27/24 - 8:15 a.m	_					
	- 9/29/24 - 8:15 a.m						
	- 9/30/24 - 8:15 a.m	i. dosage.					
		al record did not include					
	*	hold the resident's insulin nor					
		medical provider was notified					
	with clarification to	hold the resident's insulin.					
		onducted with the Nurse					
	Consultant on 10/7	/24 at 9:00 a.m. She indicated					
	_	ould be notifying the medical					
	1 ~	esident 29's insulin due to low					
	_	e 0.2 milligrams of clonidine					
		dministered if the resident's					
		lts were greater than 160. She					
		cal provider review the clonidine					
	order.						
	5. The clinical reco	rd for Resident 95 was reviewed					
		p.m. The diagnoses included,					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155271	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/08/2024			
	ROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH						
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	and Alzheimer's dis							
	resident's representa orders to obtain a un test that measures h	ted 9/17/24, indicated the atives provided physician rine albumin/creatinine ratio (a ow much protein in urine) lab. iill be picked up on 9/20/24.						
	staff was to collect ratio. The	dated 9/17/24, indicated the urine for an albumin-creatine be picked up on 9/20/24.						
		cal record did not include urine sample was obtained.						
	Consultant on 10/7/	onducted with the Nurse 24 at 3:00 p.m. She indicated sample was not collected as						
	by the Nurse Consu indicated, "Policy to follow the orders physicianProcedu received pertaining implemented and fo	ian orders policy was provided ltant on 10/8/24 at 10:14 a.m. It: It is the policy of the facility of the re4. All physician orders to the resident will be ollowed throughout the course y in the facility as the orders						
F 0707	3.1-37(a)							
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/\	Vk, Full Time DON						
		and record review, the facility gistered Nurse (RN) on duty for	F 0727	F727 It is the intent of this facility to have an RN on duty at least e	10/26/2024 ight			

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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 10/08/2024		
	PROVIDER OR SUPPLIER	L R SKILLED NURSING FACILITY, TH	STREET ADDRESS, CITY, STATE, ZIP COD 8400 CLEARVISTA PL				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	I		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1110		cutive hours a day, seven		1110	consecutive hours a day seve		BITTE
		and the potential to affect 49 of			days a week.	41	
	49 residents in the f	-			what corrective action	(e)	
	19 residents in the 1	idenity.			will be accomplished for the		
	Findings include:				residents found to have bee		
	i manigs metade.				affected by the deficient	11	
	The Payroll Based	Journal (PBJ) Staffing Data			-		
		quarter of the 2024 Federal			practice;		
	_	ed the facility had no RN			No residents were identified for	or	
		the following dates: 4/7/24,			this cited deficient practice.	וכ	
	_	/4/24, 5/5/24, 5/18/24, 5/19/24,			lins cited delicient practice.		
					how other residents		
	5/27/24, 6/1/24, 6/2/24, 6/15/24, 6/16/24, and				having the potential to be		
	6/30/24.				affected by the same deficie	nt	
	On 10/3/24 at 10:20	0 a.m., the Administrator			practice will be identified an		
		Nursing Schedule for the			1 -		
		along with the time sheets for			what corrective action(s) will	.1	
		he Director of Nursing (DON),			be taken;		
		a.m., indicated there was no RN			All regidents have the natent	ial ta	
		ay, 4/20/24, and Sunday,			All residents have the potenti be affected by the deficient	ai lu	
	_	nedule and time sheets did			practice, therefore, this plan of	√f.	
	· ·	e for 4/7/24, 5/4/24, 5/5/24,			correction applied to all reside		
		/27/24, 6/1/24, 6/2/24, 6/15/24,			that resident in the facility.	11110	
	6/16/24, and 6/30/2				that resident in the lacility.		
	An interview was c	onducted with the Staffing			what measures will be		
	Coordinator (SC) as	nd the DON on 10/3/24 at 11:28			put into place and what		
	a.m. The SC indica	ted she'd been the staffing			systemic changes will be ma	ade	
	coordinator for alm	ost three years. The facility did			to ensure that the deficient		
	not have RN covera	age on 4/20/24 and 4/21/24. RN			practice does not recur;		
	9 was the facility's RN weekend option nurse, but				The Director of Nursing/desig	nee	
	she did not work or	n those dates, and they hadn't			completed education with		
	used agency nursing	g staff since 4/1/24. The DON			scheduler on 10/23/2024 rela	ted to	
	indicated he worked	d Monday through Friday, and			CMS guideline on RN coverage	ge	
	only worked weeke	ends sometimes.			requirement. Additionally, an	-	
					employee who fails to comply	-	
	An interview was c	onducted with the Nurse			the points of the in-service ma		
	Consultant (NC) on	10/4/24 at 11:55 a.m. She			further educated and/or	-	
	` ′	no facility policy regarding RN			progressively disciplined as		
	coverage.	· - · -			indicated.		

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

PRINTED: 12/12/2024 FORM APPROVED OMB NO. 0938-039

		X2) MULTIPLE CONSTRUCTION X3) DATE SURVI A. BUILDING 00 COMPLETED B. WING 10/08/2024			LETED		
	PROVIDER OR SUPPLIE	R SKILLED NURSING FACILITY, TH	ΗE	8400 C	ADDRESS, CITY, STATE, ZIP COD LEARVISTA PL IAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
	This citation relate and IN00428580. 3.1-17(b)(3)	s to Complaints IN00433065			how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be printo place; The DON/Designee will Audit RN coverage x 8 consecutive hours will be completed 5 time week x 4 weeks then 3 times week x 4 weeks, then once and yes	e ity out of es a a conth thin e oring ly will ver, . Any citten	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Sto	re/Prepare/Serve-Sanitary	F 08	312	F812		10/26/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			COMPLETED
		155271	B. WING 10/08/2024			
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER	S.			LEARVISTA PL	
WATERS	OF CASTLETON	SKILLED NURSING FACILITY, TH	E		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	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE
		on, interview, and record			It is the policy of this facility to	
	-	failed to hold food on a steam			hold food on the steam table a	at
	_	atures with the potential to			safe temperatures.	
	affect 48 of 49 resid	lents residing at the facility.			what corrective action(-
					will be accomplished for tho	
	Findings include:				residents found to have been	n
					affected by the deficient	
		p.m., the lunch service was			practice;	
		lity's main kitchen with Facility				
		indicated he was serving the			The DON/Designee assessed	all
	•	am table contained a serving			residents on DATE and no	
		ables and a serving pan of			negative outcomes identified.	
		The temperature of the mixed				
	_	ined at 121.8 degrees			how other residents	
		temperature of the bourbon			having the potential to be	
		ined at 107 degrees F. FC 1			affected by the same deficie	
	_	rature of the mixed vegetables,			practice will be identified and	
		h filets should have been at			what corrective action(s) wil	l
	least 135 degrees F.				be taken;	
	0 10/4/24 + 12 46				All residents have the potentia	al to
		B p.m., the lunch service was			be affected by the deficient	
		lity's upstairs kitchenette. FC			practice, therefore, this plan o	
		finishing the upstairs dining			correction applies to all reside	ms
		. The steam table contained a ch fries. The temperature of			that reside in the facility.	
		s obtained at 120 degrees F.				
	the Prench mes was	s obtained at 120 degrees F.			what measures will be	
	On 10/4/24 at 1.50	p.m., the Regional Director of			put into place and what	
		d the Food Safety Handout,			systemic changes will be ma	nde
		hich read, " Foods should be			to ensure that the deficient	iu c
		e temperatures to maintain			practice does not recur;	
		eld at 135 degrees Fahrenheit			The Dietary Manager in-service	red
	to 170 degrees Fahr				the dietary staff on Food Safe	
	1,0 23g1005 1 till				and food temperatures when	•
	3.1-21(a)(2)				the steam table on DATE.	'8
	(-)(-)				Additionally, any staff that fails	s to
					comply with the points of this	·
					in-service will be further educa	ated
					and/or disciplined as indicated	
					how the corrective	

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES		B NO. 0938-039			
STATEMENT 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	_	10/08	/2024
NAMEOFI	DROVIDED OF CUIPN IEE		•	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF			8400 C	LEARVISTA PL		
WATERS	S OF CASTLETON	SKILLED NURSING FACILITY, ¹	THE	INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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
					action(s) will be monitored to		
					ensure the deficient practice		
					will not recur, i.e., what quali	-	
					assurance program will be p	ut	
					into place;		
					The Dietory manager will as in	nloto	
					The Dietary manager will com Food temperature QA Audit Fo		
					for 10 random meals weekly x		
					weeks, 5 random meals week		
					4 weeks, and then 3 random	, , , , , , , , , , , , ,	
					meals monthly x 4 months. If	the	
					facility is within 95% compliand		
					at the end of the 6 months; the		
					monitoring can be stopped.		
					Results of the monitoring will be	ре	
					reviewed at the monthly QAPI		
					meeting. Any concerns will ha	ve	
					been addressed. However, an	y	
					patterns will be identified. Any		
					needed Action Plan will be wri	tten	
					by the QAPI committee. Any		
					written Action Plan will be		
					monitored by the Administrato	r	
					weekly until resolved.		
					-		
					by what date the syster	nic	
					changes for each deficiency		
					will be completed. October 2	۷6,	
					2024		
F 0851	483.70(q)(1)-(5)						
SS=C	Payroll Based Jou	ırnal					
Bldg. 00							

Based on interview and record review, the facility

F 0851

F851

It is the intent of this facility to

10/26/2024

12/12/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/08/2024 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to submit to Centers for Medicare and submit to Centers or Medicare Medicaid Services (CMS) accurate direct care and Medicaid Services staffing information regarding the correct accurate direct care staffing category of work for a Registered Nurse for 49 of information. what corrective action(s) 49 residents in the facility. will be accomplished for those Findings include: residents found to have been affected by the deficient The Payroll Based Journal (PBJ) Staffing Data practice; Report for the third quarter of the 2024 Federal The errors identified on the Fiscal Year indicated the facility had no RN payroll-based journal have been coverage hours on the following dates: 4/7/24, corrected by the Administrator. 4/20/24, 4/21/24, 5/4/24, 5/5/24, 5/18/24, 5/19/24, 5/27/24, 6/1/24, 6/2/24, 6/15/24, 6/16/24, and how other residents 6/30/24. having the potential to be affected by the same deficient On 10/3/24 at 10:20 a.m., the Administrator practice will be identified and provided the Daily Nursing Schedule for the what corrective action(s) will above dates. They, along with the time sheets for be taken; RN 9 provided by the DON (Director of Nursing), on 10/4/24 at 10:45 a.m., indicated there was RN All residents have the potential to coverage on 4/7/24, 5/4/24, 5/5/24, 5/18/24, 5/19/24, be affected by the alleged cited 5/27/24, 6/1/24, 6/2/24, 6/15/24, 6/16/24, and practice, therefore, this plan of 6/30/24. correction applies to all residents that reside in the facility. An interview was conducted with the Staffing Coordinator (SC) and the DON on 10/3/24 at 11:28 what measures will be a.m. The SC indicated she'd been the staffing put into place and what coordinator for almost three years. RN 9 was the systemic changes will be made facility's RN weekend option nurse who worked to ensure that the deficient on 4/7/24, 5/4/24, 5/5/24, 5/18/24, 5/19/24, 5/27/24, practice does not recur; 6/1/24, 6/2/24, 6/15/24, 6/16/24, and 6/30/24. RN 9 just became an RN in March 2024 and she was The Administrator/Designee unsure if the system that sends in the PBJ data in-serviced the Business office was updated to reflect RN 9's title change to an manager on updating and RN. submitting Employee Change Forms when a change in Licensure occurs on 10/23/24.

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https://mylicense.in.gov/everification/Search.aspx

, RN 9's active RN license was issued effective

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Additionally, any staff members

fails to comply with points of this

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155271		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/08/2024	
	PROVIDER OR SUPPLIED	SKILLED NURSING FACILITY,	8400 0	ADDRESS, CITY, STATE, ZIP COD CLEARVISTA PL NAPOLIS, IN 46256	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF 3/21/24. An interview was compared to the second	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION conducted with the Nurse	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) in-service will be further educe and/or disciplined as indicate	DATE
	Consultant (NC) or	n 10/4/24 at 11:55 a.m. She no facility policy regarding PBJ		how the corrective action(s) will be monitored ensure the deficient practic will not recur, i.e., what qua assurance program will be into place; The Administrator will audit employees with a licensure change and all new employee correct job class coding wee 6 months. If the facility is win 95% compliance after the 6 months, the monitoring will b stopped. Results of the monit will be reviewed at the month QAPI meeting. Any concerns have been addressed. Howe any patterns will be identified needed Action Plan will be we by the QAPI committee. Any written Action Plan will be monitored by the Administrative weekly until resolved. by what date the system changes for each deficiency will be completed. October 2024	es for kly x thin e toring hly s will ver, l. Any ritten or
F 0887 SS=E Bldg. 00	483.80(d)(3)(i)-(vi COVID-19 Immur				

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Event ID:

KCML11 Facility ID: 000171

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPL	COMPLETED	
		155271	B. WI				2024	
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹		l	LEARVISTA PL			
WATERS	S OF CASTLETON	SKILLED NURSING FACILITY, TH	4E		IAPOLIS, IN 46256			
WAILING		SKILLED NORSING FACILITY, 11	<u>'</u>	INDIAN				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
			F 08	387	F887		10/26/2024	
		and record review, the facility			It is the intent of this facility to			
		f 5 residents medical records			ensure residents or residents			
		ation that indicated the			representative are provided			
		representative was provided			education regarding the benef			
		g the benefits and potential			and potential risks associated			
		th the 2023-2024 COVID-19			the 2023-2024 COVID-19 vac	cine,		
	· · · · · · · · · · · · · · · · · · ·	e COVID-19 vaccine was			document in the EMR if the			
		resident; or whether the			COVID-19 vaccine is administ			
		eive the COVID-19 vaccine			or if the COVID-19 vaccine wa			
		traindications or refusal for 4 of			declined or was not administe			
	5 residents reviewed for COVID-19 immunization.				due to medical contraindications.			
	(Residents 11, 18, 2	20, 24, and 30)			What corrective action will be			
					accomplished for those			
	Findings include:				residents found to have been	า		
		0. 7. 11. 14. 10. 00. 01			affected by the deficient			
		s for Residents 11, 18, 20, 24,			practice			
	and 30 were review	ved on 10/3/24 at 11:48 a.m.			Resident #11 declined the			
	D 11 (11 1	7/0/20			COVID-19 booster on 10/3/24			
		mitted to the facility on 7/8/20.			Resident #18 declined the			
		al record indicated he was last			COVID-19 booster on 10/3/24			
		OVID-19 vaccine on 7/7/22.			Resident #20 no longer reside	s in		
		mation in his clinical record lent 11 or Resident 11's			the facility, Resident #24			
					consented for the COVID-19			
		provided education regarding tential risks associated with			booster on 10/3/24 and receive the booster on 10/23/24, Resignal			
	_	VID-19 vaccine; whether the			#30 consented for the COVID			
		-19 vaccine was administered to			booster on 10/4/24 and receiv			
		ether Resident 11 did not			the booster on 10/22/24, by the			
	· ·	024 COVID-19 vaccine due to			DON/Designee. The	C		
	medical contraindic				DON/Designee also provided			
					education regarding risks and			
	Resident 18 was ad	mitted to the facility on 7/2/18.			benefits associated with the			
		cal record indicated she was last			vaccine and documented in th	e		
		OVID-19 vaccine on 7/6/22.			EMR for both administered an			
		mation in her clinical record			declined vaccines on DATE.			
		lent 18 or Resident 18's						
		provided education regarding			How other residents having	the		
		tential risks associated with			potential to be affected by th			
	_	VID-19 vaccine; whether the			same deficient practice will be			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		a. building <u>00</u>		00	COMPLETED		
		B. WING 10/08/2024					
				_		10,00,	
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					LEARVISTA PL		
WATERS	OF CASTLETON	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	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2023-2024 COVID	-19 vaccine was administered to			identified and what correctiv	e	
	Resident 18; or who	ether Resident 18 did not			action will be taken.		
	receive the 2023-20	24 COVID-19 vaccine due to			The Director of Nursing/design	nee	
	medical contraindic	eations or refusal.			obtained new consent/declina	tions	
					for COVID-19 booster for curre	ent	
	Resident 20 was ad	mitted to the facility on 3/2/20.			residents on 10/2/24. Current		
		al record indicated he was last			residents that consented to		
		OVID-19 vaccine on 7/6/22.			receive COVID-19 booster ha	d	
		nation in his clinical record			orders placed in EHR on		
		lent 20 or Resident 20's			10/23/24. Current residents h	ad	
	representative was	provided education regarding			consents/declinations added t	0	
		tential risks associated with			their EHR 10/23/24. Residents		
	_	VID-19 vaccine; whether the			and/or resident representative		
		-19 vaccine was administered to			received education reading he		
		ether Resident 20 did not			benefits and potential risks		
	-	024 COVID-19 vaccine due to			associated with the 2023-204		
	medical contraindic				COVID-19 vaccine.		
		autons of forusar.			OOVID-13 VACCING.		
	Resident 24 was ad	mitted to the facility on 5/3/21.			What measures will be put ir	1	
	Resident 24's clinic	al record indicated she was last			place and what systemic		
	administered the Co	OVID-19 vaccine on 7/6/22.			changes will be made to		
	There was no inform	nation in her clinical record			ensure that the deficient		
	that indicated Resid	lent 24 or Resident 24's			practice does not recur.		
	representative was	provided education regarding			The Director of Nursing/design	nee	
	the benefits and pot	ential risks associated with			completed education on 10/23	3//24	
	the 2023-2024 COV	VID-19 vaccine; whether the			with Licensed Nurses and		
	2023-2024 COVID	-19 vaccine was administered to			Admissions related		
	Resident 24; or who	ether Resident 24 did not			consent/declinations of the		
	receive the 2023-20	024 COVID-19 vaccine due to			2023-2024 COVID-19 vaccine) ,	
	medical contraindic	eations or refusal.			administering booster, and		
					documenting in resident HER	and	
	Resident 30 was ad	mitted to the facility on			providing education. Addition		
		s no information in Resident			any employee who fails to cor	-	
	30's clinical record	that indicated Resident 30 or			with the points of the in-servic		
	Resident 30's repres	sentative was provided			may be further educated and/		
	_	g the benefits and potential			progressively disciplined as		
		h the 2023-2024 COVID-19			indicated.		
		e 2023-2024 COVID-19 vaccine					
		Resident 30; or whether			How the corrective action wi	II	

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Resident 30 did not receive the 2023-2024

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Facility ID: 000171

be monitored to ensure the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> COMPI			LETED		
		155271	B. WING 10/08/2024			/2024	
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			LEARVISTA PL		
\//ATED9	OF CASTLETON	SKILLED NURSING FACILITY, TH	=		IAPOLIS, IN 46256		
VVATERS	OF CASILETON	ONILLED NORSING FACILITY, TH	<u></u>	INDIAN			
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	COVID-19 vaccine				deficient practice will not		
	contraindications or	refusal.			recur, i.e what quality		
					assurance program will be p	ut	
		onducted with the Nurse			into place:		
	` '	10/4/24 at 10:45 a.m. She			The DON/Designee will comp	leted	
	-	no verification the 2023-2024			the COVID-19		
		tion was offered, refused,			consent/declinations order au		
	•	licated, or that education			tool will be completed on new		
		2024 COVID-19 vaccination			admissions and re-admissions		
	was provided to Res	sidents 11, 18, 20, 24, and 30.			administering and documenting	•	
		B . B . W . T			administration or declination a		
		ne Post Public Health		education provide in the EMR 5			
		rd and Guidelines policy on		days a week x 4 weeks,3 days a			
		n. It read, "The facility will	week, x 2 months, then weekly x 4				
		ge everyone to remain up to	months. The DON/Designee will				
		mended Covid-19 vaccine			audit residents that have not		
		ersonnel, residents and			received the 2023-2024 COVI		
		red resources and counseled			vaccine once a month x 6 mon		
	-	the importance of the			for consents and declinations		
		The facility will provide			educations provided. If the fa	-	
		al alerts (signs, posters) to			is within 95% compliance at the	1e	
	•	aware of recommended IPC			end of the 6 months; then		
	_	on and Control] practices in the			monitoring can be stopped.	ha	1
	facility." The policy	resident's clinical record			Results of the monitoring will be		
		he resident or resident			reviewed at the monthly QAPI		
		provided education regarding			meeting. Any concerns will ha		
		ential risks associated with			been addressed. However, an	•	
	-	cine; whether the COVID-19			patterns will be identified. Any needed Action Plan will be wri		
		stered to the resident; or			by the QAPI committee. Any	ıu c ii	
		t did not receive the COVID-19			written Action Plan will be		
		ical contraindications or			monitored by the Administrato	\r	
	refusal.	John John amaron on			weekly until resolved.	′1	
	1014041.				By what date the systemic		
					changes for each deficient w	/ill	
					be completed. 10/26/2024		
					50 0011pictod. 10/20/2024		

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

PRINTED: 12/12/2024 FORM APPROVED OMB NO. 0938-039

SIB NO. VOO W							
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155271	B. WING			10/08/2024	
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	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
			l	l			

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