STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. Building B. Wing	09/13/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34850 Based on observation, interview, and record review, the facility failed to ensure an insulin flex pen was primed prior to administration of an insulin dosage for 1 of 3 residents observed for medication administration. (Resident 104) Findings include: The clinical record for Resident 104 was reviewed on 9/10/24 at 11:00 a.m. The diagnoses included, but were not limited to, type 1 diabetes mellitus. A physician order, dated 8/24/24, indicated the resident was to receive 8 units of Humulin N insulin (intermediate acting insulin) twice a day. An observation was made of Resident 104's medication administration with Licensed Practical Nurse (LPN) 3 on 9/9/24 at 8:27 p.m. LPN 3 was observed preparing the resident's 8 units of Humulin N insulin utilizing an insulin flex pen. LPN 3 used the dosage knob on the flex pen to dial up 8 units of insulin. LPN 3 entered the resident's room and administered the 8 units of insulin to the resident. There was no observation of priming the flex pen prior to dialing up the 8 unit dosage the resident was to receive. An interview was conducted with LPN 3 on 9/9/24 at 8:38 p.m. She indicated she normally primed the insulin flex pen with two units of insulin but had forgotten. [NAME] Lilly and Company, Humulin N Pen manufacture instructions at website www.pi.lilly.com dated 6/2022, was retrieved on 9/15/24. It indicated the following, Instructions for Use .Priming your Pen. Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 8: To prime your pen, turn the dose knob to select 2 units. Step 9: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles to top. Step 10: Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 8 to 10, no more than 4 times. If you still do not see insulin, change the needle and repeat priming steps 8 to 10 . 3.1-37(a)

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40287 Based on observation, interview, and record review, the facility failed to timely develop and implement an individualized behavior plan of care for 1 of 1 resident reviewed for behaviors (Resident 15). Findings include: The clinical record for Resident 15 was reviewed on 9/10/24 at 1:52 p.m. The diagnoses included, but were not limited to, dementia, stroke, aphasia (decreased ability to express and understand language), major depressive disorder with psychotic symptoms. He was admitted to the facility from a psychiatric hospital on 8/5/24. A physician's order, dated 8/5/24, indicated he was to receive quetiapine (anti-psychotic medication) 100 milligrams (mg) three times daily. A physician's order, dated 8/5/24, indicated he was to receive divalproex sodium (seizure medication and mood stabilizer) delayed release tablet 500 mg twice daily. A physician's order, dated 8/5/24, indicated Resident 15 exhibited a target behavior. Each shift was to chart the number of episodes the targeted behavior had occurred, interventions utilized, and the outcome of the interventions. The target behavior was not identified in the physician's order. A Speech Therapy Evaluation and Plan of Treatment, dated 8/6/24, indicated he had a dx of major depressive disorder, recurrent, severe with psychotic symptoms, mild cognitive impairment, cognitive communication deficit, and aphasia. He was unable to successfully complete formal aphasia assessment because he became upset and cried. An Admission Minimum Data Set (MDS) assessment, dated 8/12/24, indicated he was able to make himself understood and understand others. His speech was clear, and he was cognitively intact. He spoke English and did not need an interpreter. A care plan, initiated 8/12/24, indicated Resident 15 had impaired cognitive function and impaired thought process related to his vascular dementia with behavioral disturbances. The goal was for him to be able to communicate his basic needs daily. The interventions included to administer his medications as ordered, initiated 8/12/24, to use his preferred name, identify yourself at each interaction, face him when speaking and make eye contact, reduce distraction, use simple direct sentences, provide him with necessary cues, stop and return if he became agitated, initiated 8/12/24, and provide constant routine and care givers as much as possible. The clinical record did not contain a care plan addressing Resident 15's diagnosis of aphasia. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A general progress noted, dated 8/13/24, indicated Resident 15 was cleaning out his billfold. He was asked how he was doing by the staff member, and he started yelling at them. The staff member asked Resident 15 if he wanted a cup of coffee and Resident 15 became more combative with the staff member, who then left the room. Resident 15 was reapproached fifteen minutes later, and he was in a different mood and indicated he would love a big cup of coffee with cream and sugar. A mood and behavior note, dated 8/14/24, indicated Resident 15 had an aggressive verbal tone when medications were given. He then instantly began talking in a pleasant way. A care plan progress note, dated 8/14/24, indicated a care plan meeting was held with Resident 15's power of attorney (POA). The Interdisciplinary team (IDT) expressed Resident 15 had been pleasant at the facility and had not exhibited any behaviors like those exhibited at the hospital. Mental health services were offered and the POA agreed and gave consent. A general progress note, dated 8/14/24, indicated that a STAT (to be done right away) order for a urinalysis with culture and sensitivity, a complete blood count (CBC), and a basic metabolic panel (BMP) had been received. The 8/14/24 urinalysis was completed with no significant findings and no culture was indicated on the report. A mood and behavior note, dated 8/24/24, indicated Resident 15 became extremely upset with a certified nurse aide (CNA) for assisting him while showering. Resident 15 was educated as to why someone from the staff had to be able to ensure his safety while showering. Resident 15 yelled and cursed at the writer but stated understanding. A social services note, dated 8/26/24, indicated Resident 15 was heard yelling and was found pointing a finger in CNA's face and yelling, that is not it!. Attempts were made to calm Resident 15 down. He was frustrated, indicating the denture adhesive the CNA had was not denture adhesive. Resident 15 continued to yell. He was calmed by putting the denture adhesive onto the dentures and having Resident 15 put the dentures in his mouth and indicated the adhesive had not worked. Resident 15 was informed not to yell and get into staff's faces as it scared the staff due to his stature. Approximately 30 minutes later, Resident 15 had come to the social services office and started sobbing. He indicated he was sorry. He also apologized to CNA. Resident 15 would be seen by the in-house mental health services on the next visit. Resident 15 was admitted to an acute care hospital due to a change in condition on 8/27/24. The Nurse Administration Record for August 2024 did not contain documentation of any behaviors occurring, interventions utilized, or outcomes of interventions. The clinical record did not contain a care plan related to behaviors or resident specific interventions to be attempted when behaviors occurred. Resident 15 was readmitted from the acute care hospital, on 9/1/24, following a hospital stay for a possible stroke. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 9/1/24 at 2:46 p.m., indicated he was to receive amoxicillin (antibiotic) tablet 500 mg every eight hours for 10 days for a urinary tract infection. A physician's order, dated 9/1/24 at 2:46 p.m., indicated Resident 15 exhibited anxiety and agitation as target behaviors. Each shift was to chart the number of episodes the targeted behavior had occurred, interventions utilized, and the outcome of the interventions. A general progress note, dated 9/1/24 at 7:09 p.m., indicated that Resident 15 was going up to staff members, hugging and kissing them on the face and head excessively. He was going back and forth between laughing, crying, and expressing great thanks and love for the staff members. He was hard to redirect until he let go by himself. He had wrapped his arms around a staff member's neck and held the staff member while he kissed all over their head and face. Resident 15 then began crying very hard expressing love and thanks. Staff member was finally able to convince Resident 15 to let go of their neck and to go to their room to rest. The physician, Director of Nursing (DON) were notified, and a new order was received to obtain a STAT urinalysis, CBC, and complete metabolic panel (CMP). The urine was obtained. A physician's order, dated 9/1/24 at 11:45 p.m., indicated Resident 15 was to receive a psychiatric consultation. A medical practitioner note, dated 9/3/24, indicated that Resident 15's quetiapine was discontinued at the acute care hospital, and he was being weaned off the divalproex sodium. Resident 15 was agitated at the time during the visit and stated he needed to go somewhere. Nursing staff reported frequent emotion lability and agitated to tearful throughout the day. Power of Attorney was aggregable to starting Nuedexta (medication to treat emotional lability). Resident 15 displayed depression, agitation, and confusion. He did not refuse medications or care. A physician's order, dated 9/3/24 at 2:15 p.m., indicated Resident 15 was to receive Nuedexta capsule 20-10 mg daily for seven days. A care plan, initiated 9/8/24, indicated Resident 15 had an alteration in his neurological status related to his history of a stroke. He had aphasia. The goal was for him to be able to communicate his needs daily. The interventions included, but were not limited to, administer medications as ordered, provide cues, and reorientation as needed. A mood and behavior note, dated 9/9/24 at 5:49 a.m., indicated Resident 15 was observed going into the front office, picking up papers, envelopes, and batteries and putting them inside a black paper bag, taking them into his room. He yelled and raised his voice, cursing and telling staff to leave him alone. He refused redirection from staff. A social services note, dated 9/10/24 at 8:10 a.m., indicated Resident 15 had stated he moved himself because he liked another room better. He had settled in without difficulty and his POA was notified. On 9/10/24 at 1:52 p.m., Resident 15 was observed in his room. He was talking in a pleasant tone with an accent. He then became upset and started to yell he just wants to be happy. He indicated he wanted to go home, and the facility would not let him. He denied the need for an interpreter and indicated he could speak and understand both English and Spanish. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medical practitioner note, dated 9/10/24 at 2:41 p.m., indicated Resident 15 was seen for an acute visit. Nursing had reported frequent behaviors. His emotional lability had improved. The plan was to restart the quetiapine for vascular dementia with behavior disturbance and to continue his Nuedexta. A Psychiatric Telehealth Diagnostic Evaluation, dated 9/10/24, indicated he was referred for assessment of mood, cognitive assessment, and follow up to allegations made. Staff report resident showed labile mood, some confusion, and disorientation. A referral was reportedly prompted by accusations of concerns during a previous hospital stay. He was admitted to the facility in August after an inpatient hospital stay for dementia related behaviors. A Psychiatric Initial Consult, dated 9/11/24, indicated since admission to the facility, he had frequent episodes of agitation and verbal aggression. The review of systems indicated he had psychotic symptoms of paranoid delusions. His mood symptoms included agitation, crying, angry and depressed mood, and lability. He displayed anxiety symptoms of being irritable. He had displayed verbal aggression and severe restlessness. His cognition was impaired. The plan was for him to have an increase in his dose of anti-depressant medications, continue to receive Nuedexta, continue quetiapine as ordered. Lorazepam (anti-anxiety medication) 0.5 mg tablets was to be started twice daily, as needed for agitation, for fourteen days. A care plan, initiated 9/12/24, indicated Resident 15 would become anxious and agitated. He would curse at staff, throw items in room, and yell. He experienced mood swings. He would yell about needing to leave the facility for appointments that were not scheduled and wanting to go home. The goal was for Resident 15 to have fewer episodes of anxiousness. The interventions included, but were not limited to, administer medications as ordered, allow him to go out on the porch per his preference, anticipate and meet his needs, and to call his son to allow him to speak to him. Also, offer consolation by offering a hug when asked, mental health services as indicated, monitor behavior episodes and attempt to determine underlying cause, and to consider location, time of day, persons involved, and situations. Document behaviors and potential causes. Offer his music on the compact disk player and headphones in his room, praise any indication of progress or improvement in behaviors, and provide a program of activities of interest and accommodate his status. The Nurse Administration Record for September 2024 did not contain documentation of any behaviors occurring, interventions utilized, or outcomes of interventions. During an interview on 9/12/24 at 11:06 a.m., the Social Services Director (SSD) indicated Resident 15 had been admitted in August. He was receiving quetiapine and divalproex sodium when he was admitted on [DATE]. These medications had been changed during his hospitalization on [DATE]. Resident15's mood was very labile; he would go from one mood to another very quickly. Behavior documentation was normally found in the nursing notes. During an interview on 9/12/24 at 2:17 p.m., the SSD indicated Resident 15 had been seen by the psychiatric provided for an initial evaluation on 9/11/24. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/13/24 at 11:32 a.m., the SSD indicated Resident 15 had been referred to the psychiatric provider on 8/14/24. The psychiatric provider was normally at the facility every Tuesday. Resident 15 had not been seen on Tuesday, 8/20/24, because the nursing staff accidently told the psychiatric provider Resident 15 was no longer a resident at the facility. Resident 15 had a change in condition and was sent to the hospital on Tuesday 8/27/24. Resident 15 readmitted to the facility, on 9/1/24, and was not seen by the psychiatric provider on Tuesday, 9/3/24, due to the psychiatric provider not being able to see him due to time constraints. He had been seen by the psychiatric provider via telehealth, on 9/10/24, and in person on 9/11/24. Resident 15 had not displayed behaviors when he first admitted in August. She would have preferred Resident 15 be seen by a psychiatric provider earlier than 9/11/24. During an interview on 9/13/24 at 11:42 a.m., the Regional Nurse Consultant (RNC) indicated that Resident 15's explosions were short in durations and then he would go back to normal. During an interview on 9/13/24 at 1:50 p.m., the Regional Reimbursement Nurse (RRN) indicated that Resident 15 was admitted to an inpatient psychiatric hospital in June of 2024, after being hospitalized for a stroke. Resident 15 had expressive aphasia from his stroke. While hospitalized , Resident 15 had refused to use a communication board and while at the psychiatric hospital, when he had aggressive episodes or outburst, he would go to his room and calm down. Resident 15 continued to display that pattern at the facility. He had been re-evaluated by speech therapy, on 9/4/24, but had refused to participate. Resident 15 had been more ramped up than normal this week. His tone had become more aggressive since the discontinuation of his quetiapine and divalproex sodium during his most recent hospital stay. Resident 15 seemed to become frustrated and upset when he was unable to express his wants or needs. There had not been a care plan addressing his aphasia until 9/8/24. On 9/13/24 at 9:46 a.m., the RNC provided the Behavior Management policy, last revised 6/2020, which read .The concept of behavior management is an interdisciplinary process. The key components of this process are: identifying residents whose behaviors may pose a risk to self or others; developing individual and practical care strategies based on assessed needs; implementing the behavior management program; and ongoing assessment, monitoring, and evaluation of the effectiveness of the behavior management program including the effectiveness of psychoactive drugs. The goal of any behavior management process is to maintain function and improve quality of life. The goal of the interdisciplinary team is to promptly identify behavior management issues and develop and effective management program . When a resident displays adverse behavioral symptoms [e.g., crying, yelling, hitting, biting etc], Licensed Nursing Staff will assess the behavioral symptoms to determine a possible causal factor, contact the Attending Physician, and implement non-drug interventions to alleviate the behavioral symptoms before initiating any psychotherapeutic agent[s] . Assess Causal Factor A. When a resident exhibits adverse behavioral symptoms [e.g., crying, yelling, hitting, biting, etc], Licensed Nursing Staff will document the behavior in the medical record, noting the time the behavior[s] occurred. antecedent events, possible causal factors and interventions . 3.1-37(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 34850 Based on interview and record review, the facility failed to ensure a resident's blood pressure was within the parameter to administer midodrine (a medication to treat low blood pressure) for 1 of 5 residents reviewed for unnecessary medications. (Resident 16) Findings include: The clinical record for Resident 16 was reviewed on 9/12/24 at 11:30 a.m. The diagnoses included, but were not limited to, hypertension (high blood pressure). A physician order, dated 8/28/24, indicated the resident was to receive 5 milligrams of midodrine twice a day for hypotension (low blood pressure). The staff was to hold the medication if the resident's systolic blood pressure (pressure your blood is pushing against your artery walls when the heart beats/first number of blood pressure) was greater than 110. The September 2024 Medication Administration Record (MAR) indicated the resident's midodrine medication was administered in the mornings and nightly, on 9/1/24, through the morning of 9/12/24. The MAR did not include blood pressure readings obtained prior to administration of the midodrine medication. An interview was conducted with the Regional Nurse Consultant (RNC) on 9/12/24 at 1:38 p.m. He indicated the staff should have been obtaining blood pressures for Resident 16 prior to the administration of midodrine medication. The Administration Procedures for All Medications policy, was provided by the RNC on 9/12/24 at 9:20 a.m. It indicated .III. 5 rights .1. Prior to removing the mediation package/container from the cart/drawer .d. check for vital signs or other tests to be done during or prior to medication administration . 3.1-48(a)(3)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34850 Based on observation, interview, and record review, the facility failed to ensure the kitchen was maintained clean and in good repair; the food was stored with a label and dated; the water temperatures were monitored for the dishwasher; and the kitchen staff did not store personal drinks in the walk-in-refrigerator. This had a potential to affect 52 of 53 residents that consume food from the kitchen. Findings include: An observation was made of the kitchen on 9/9/24 at 7:18 p.m. The dishwasher area and the dry storage area flooring tiles were observed cracked and broken. The wall behind the dishwasher and in the back of the oven had a yellow substance dripping down the wall. During the tour, Dietary Aide (DA) 2 was observed running the dishwasher. The dishwasher was running three times, and each time the rinse cycle had reached 165 degrees Fahrenheit (F). A manufacture plate on the dishwasher indicated the wash cycle should reach 150 degrees F, and the rinse cycle should reach 180 degrees F. DA 2 indicated he doesn't look at the gauges while he was running the dishwasher. After, a rack that contained dishes was observed. The bottom rack with the dishes had food debris scattered on the bottom rack with the dishes. The DA indicated the dishes on the rack were clean. During the tour, refrigerators were observed. The refrigerator in the food prep area had the following food items in the refrigerator that were not labeled or dated: One package of turkey lunch meat, One block of butter, A medical tray of several pudding cups, Four packages of cheese, One bowl of oranges, and Five bowls of salads. A walk-in-refrigerator was observed with the following food times not labeled or dated: Four cups of orange juice, Three 16 ounces bottles of Pepsi, One 16-ounce bottle of tea, One cup of red juice substance, and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Five cups of apple dessert. A kitchen tour was conducted with Regional Nurse Consultant (RNC) on 9/9/24 at 7:43 p.m. During the tour, DA 2 was observed walking in the walk-in-refrigerator and retrieving the 16-ounce bottle of tea. After, DA 2 drank the tea. The dishwasher log hanging on the wall was observed with the RNC. The dishwasher log did not include wash or rinse cycle water temperatures recorded on 9/8/24 for breakfast, lunch, or dinner. On 9/9/24, there were no recordings of the water temperature readings for breakfast or lunch. An interview was conducted with Registered Dietitian on 9/10/24 at 10:34 a.m. She indicated the dishwasher was reaching the rinse water temperature of 180 degrees F, but the rinse cycle gauge was broken. All food items should be labeled and dated. The staff's personal drinks should not be stored in the walk-in-refrigerators. The kitchen flooring, and the walls in the dishwasher area and behind the oven would be addressed. A Cleaning Schedule policy was provided by the Director of Nursing on 9/11/24 at 9:55 a.m. It indicated the following, .Policy The nutrition services staff will maintain a sanitary environment in the nutrition services department by complying with the routine cleaning schedule developed by the Nutrition services manager . A dish machine temperature recording policy was provided by the RNC on 9/11/24 at 9:38 a.m. It indicated Purpose. To establish guidelines for temperature monitoring and recording during the use of the dish machine. Policy. The dish machine will be routinely monitored during use to ensure appropriate temperatures. A record of the dish machine's temperatures will be maintained in the nutrition services department .II. Allow the dish machine to run through several cycles in order to bring the water temperatures up to the proper level by sending several empty racks through the machine. III. Reach temperature gauges on the machine while racks are in the machine. IV. Record temperatures daily on Dish Machine Temperature Log. V. Any temperatures that are below the required levels as outlined by the manufacture's guidelines, must be brought to the attention of the Nutrition services manager promptly .VII. High temperature dish machine wash period should be at least 40 seconds with a temperature of no less than 160 degrees. The sanitizing period should be at least 15 seconds with a temperature of 180 degrees, but not to exceed 190 degrees .IX. Dish machine temperature log must be completed by a nutrition services staff member directly involved in the dishwasher process. A. Entries will be made daily .C. Wash and rinse temperatures must be observed and logged during the dishwashing period. D. Actual temperatures should be entered on the dish machine temperature log by the dish machine operator at the start of each meal period . A food storage policy was provided by the RNC on 9/11/24 at 9:38 a.m. It indicated, Purpose. To establish guidelines for storing, thawing, and preparing food. Policy. Food items will be stored, thawed, and prepared in accordance with good sanitary practice .C. Storage .i. Label and date all food items . 3.1-21(i)(2) 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34850 Based on observation, interview, and record review, the facility failed to ensure enhanced barrier precautions were implemented during a wound dressing change for 1 of 2 residents observed for pressure ulcers. (Resident 25) Findings include: The clinical record for Resident 25 was reviewed on 9/11/24 at 11:20 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A care plan, dated 8/19/24, indicated the resident was in enhanced barrier precautions related to a wound. A care plan, dated 5/9/24, indicated the resident's right ankle had a diabetic ulcer. A physician order, dated 8/14/24, indicated the resident's right ankle wound was to be cleansed with Dakins (antiseptic solution), apply Santyl (ointment that removes dead tissue from wounds) and calcium alginate (dressing for wounds), and cover with a gauze dressing twice a day. An observation was conducted of a wound dressing change to Resident 25 with the Director of Nursing (DON) and License Practical Nurse (LPN) 1 on 9/11/24 at 2:11 p.m. LPN 1 and the DON utilized hand hygiene and donned gloves prior to the wound dressing change. During the dressing change, the DON and LPN 1 had doffed gloves and donned on new set of gloves. There was no observation of the DON and LPN 1 donning any other personal protective equipment (PPE) that included a gown prior or during the wound dressing change. An interview was conducted with the Regional Nurse Consultant (RNC) on 9/12/24 at 9:45 a.m. He indicated there had been a misunderstanding on how long to keep a resident in enhanced barrier precautions. Resident 25 no longer had an infection in her wound. The facility staff were under the impression, once Resident 25's infection to the wound was resolved, the enhanced barrier precautions could be discontinued. An infection control policy was provided by the Administrator on 9/10/24 at 11:20 a.m. It indicated, Purpose. The (sic) ensure the Facility establishes and maintains an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements . 3.1-18(b)(1)(A) 3.1-18(j)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castleton Health Care Center	7630 E 86th St Indianapolis, IN 46256

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 34850 Based on interview and record review, the facility failed to implement an antibiotic stewardship program to ensure infections involving antibiotic usage in the facility were tracked and monitored. This had a potential to affect 53 of 53 residents that reside in the facility. Findings include: The antibiotic stewardship binder was provided by the Director of Nursing (DON) on 9/13/24 at 9:00 a.m. It included the facility's monthly tracking and monitoring of residents' infections that had utilized antibiotics. The binder did not include monthly tracking from January 2024 through May 2024 to indicate the facility was tracking or monitoring the residents' antibiotic usage. The months of June 2024, July 2024, and August 2024's antibiotic tracking sheets did not include the infection the resident had nor a method of tracking locations where the residents' with an infection were located throughout the facility. An interview was conducted with the Regional Nurse Consultant (RNC) on 9/13/24 at 10:00 a.m. He indicated the building had changed corporations in March of 2024. Unfortunately, he was unable to provide documentation from January 2024 through March 2024. The previous corporation staff were tracking and monitoring the residents' antibiotic usage. The DON started tracking and monitoring antibiotic usage in June 2024. She had not been logging the type of infection nor tracking the location of residents with an infection. It was being addressed. An Infection Prevention and Control Program policy was provided by the Administrator on 9/10/24 at 11:00 a. m. It indicated, Purpose. The (sic) ensure the Facility establishes and maintains an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements. Policy. The facility must establish an Infection Prevention and Control Program under which it 1. Identifies, investigates, controls, and prevents infections in the facility .E. Collects, analyzes and provides infection data and trends to Nursing Staff and Physicians .II. Infection Control Committee .G. Meetings .iii. Over time, committee meetings will cover at least .i. antibiotic utilization patterns and emergence of antibiotic-resistant organisms An Antibiotic Stewardship Program policy was provided by the DON on 9/13/24 at 9:00 a.m. It indicated the following, Purpose. To limit antibiotic resistance in the post-acute are setting, improve treatment efficacy and resident safety, and reduce treatment-related costs. Policy. The Antibiotic Stewardship Program (ASP) is designed to promote appropriate use of antibiotics while optimizing the treatment of infections and simultaneously reducing the possible adverse events associated with antibiotic use .V. Tracking .A. The IP [Infection Preventionist] will be responsible for infection surveillance and MDRO [multidrug-resistant organism] tracking. The IP will utilize Antibiotic Tracking Sheet