

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155245	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/24/2013
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NAME OF PROVIDER OR SUPPLIER  CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/24/13</p> <p>Facility Number: 000149 Provider Number: 155245 AIM Number: 100266840</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Castleton Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered except for the Beauty Shop closet. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated</p>	K010000	Submission of this Plan of Correction shall not constitute or be construed as an admission by Castleton Health Care Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of Nursing Care and services to the residents of Castleton Health Care Center.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>smoke detectors in all resident sleeping rooms. The facility has a capacity of 109 and had a census of 51 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the Beauty Shop closet.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/25/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors to hazardous areas such as the kitchen was held open only by devices arranged to automatically close the door upon activation of the fire alarm system. This deficient practice could affect 20 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:55 a.m. to 1:10 p.m. on 07/24/13, a piece of cardboard was wedged under the kitchen entry door from the Main Dining Room to prop the door to this hazardous area fully open. Based on interview at the</p>	K010021	<p>What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient finding? No resident was found to have a negative affect by the alleged deficient finding. How other residents having the potential to be affected by the same alleged deficient finding will be identified and what corrective action(s) will be taken? All resident have the potential to be affected by the alleged deficient finding. The dietary staff have been in-serviced on keeping the kitchen doors closed and not propped open. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient finding does not recur? The Dietary Manager/designee will audit the kitchen doors 3 times weekly for six months</p>	08/23/2013			

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	time of observation, the Maintenance Director acknowledged the door to the kitchen from the Main Dining Room was propped fully open with wedged cardboard used as a door stop.  3.1-19(b)		to ensure they are not propped open. How the corrective action(s) will be monitored to ensure the alleged deficient finding will not recur, i.e., what quality assurance program will be put into place? The Dietary Manager/designee will present the results of the weekly audits to the QA Committee during monthly QA Meetings to ensure compliance.		

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K010027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would close to form a smoke resistant barrier. LSC 19.3.7.6 requires doors in smoke barriers shall comply with Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect any 18 residents, staff and visitors in vicinity of the smoke barrier doors by the Beauty Shop if smoke was allowed to move from one smoke compartment to another.</p> <p>Findings include:  Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:55 a.m. to 1:10 p.m. on 07/24/13, the set of smoke barrier doors in the corridor</p>	K010027	What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient finding? No resident was found to have a negative affect from the alleged finding. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged finding. The smoke barrier doors by the beauty shop fully close. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? The Maintenance Director/designee will conduct audits of the smoke barrier doors to ensure they close properly. Audits will be completed weekly for 6 months. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance	08/23/2013	

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	<p>by the Beauty Shop which swing in the opposite direction failed to fully close leaving a one half inch gap between the doors at the top of the west door. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned set of smoke barrier doors failed to fully close leaving a one half inch gap between the doors at the top of the west door.</p> <p>3.1-19(b)</p>		<p>program will be put into place? The Maintenance Director/designee will present the results of the weekly audits to the QA Committee during monthly QA Meetings to ensure compliance.</p>		

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors to hazardous areas such as the kitchen closed automatically or upon activation of the fire alarm system. This deficient practice could affect 20 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:55 a.m. to 1:10 p.m. on 07/24/13, a piece of cardboard was wedged under the kitchen entry door from the Main Dining Room to prop the door to this hazardous area fully open. Based on interview at the time of observation, the Maintenance Director acknowledged the door to the kitchen from the Main Dining Room was propped fully open with wedged</p>	K010029	<p>What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient finding? No resident was found to have a negative affect by the alleged deficient finding. How other residents having the potential to be affected by the same alleged deficient finding will be identified and what corrective action(s) will be taken? All resident have the potential to be affected by the alleged deficient finding. The dietary staff have been in-serviced on keeping the kitchen doors closed and not propped open. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient finding does not recur? The Dietary Manager/designee will audit the kitchen doors 3 times weekly for six months to ensure they are not propped open. How the corrective</p>	08/23/2013	

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	cardboard used as a door stop.  3.1-19(b)		action(s) will be monitored to ensure the alleged deficient finding will not recur, i.e., what quality assurance program will be put into place? The Dietary Manager/designee will present the results of the weekly audits to the QA Committee during monthly QA Meetings to ensure compliance.		

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K010050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 4 of 4 quarters. This deficient practice affects all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Administrator and the Maintenance Director during record review from 9:15 a.m. to 10:55 a.m. on 07/24/13, second shift fire drills conducted on 10/17/12, 01/31/13, 04/25/13 and 07/17/13 were conducted at, respectively, 3:30 p.m., 4:00 p.m., 3:00 p.m. and 3:00 p.m. Based on interview at the time of record review, the Maintenance Director acknowledged second shift fire drills were not conducted at unexpected times under varying</p>	K010050	<p>What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient finding? No resident was found to have a negative affect from the alleged finding. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged finding. Fire Drills will be conducted for each shift on a quarterly basis at varying times on each shift. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? A schedule of Fire Drills at varying times on each shift has been developed. The Maintenance Director/designee will conduct Fire Drills according to the established schedule. How the corrective action(s) will be monitored to ensure the alleged</p>	08/23/2013	

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	conditions.  3.1-19(b)		deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director/designee will present the completed fire drills to the QA Committee during monthly QA Meetings to ensure adherence to schedule.	

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K010056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 closets in the Beauty Shop. This deficient practice could affect 2 residents and staff.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:55 a.m. to 1:10 p.m. on 07/24/13, the closet in the Beauty Shop was not provided with an automatic sprinkler. Based on interview at the time of observation, the Administrator and the Maintenance Director acknowledged the closet in the Beauty Shop was not provided with an automatic sprinkler.</p>	K010056	<p>What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient finding? No resident was found to have a negative affect due to the alleged finding. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged finding. The closet in the beauty shop was removed. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? The Maintenance Director/designee will complete an audit of all closets to ensure they each have sprinkler coverage. How the corrective action(s) will be monitored to</p>	08/23/2013			

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	3.1-19(b) 3.1-19(ff)		ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director/designee will present the findings of the audit to the QA Committee during the September 2013 monthly QA Meeting to ensure compliance. Any proposed new closet construction will be reviewed by the QA Committee during monthly QA Meeting to ensure any proposed closet will have sprinkler coverage.		