

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 10/17/2014
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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: 10/17/14</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 Main Shower Room and the exterior canopy by Room 201. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The</p>	K010000	<p>Submission of this Plan of Correction shall not constitute or be construed as an admission by Castleton Healthcare Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of nursing care and services to the residents at Castleton Healthcare Center. Castleton Healthcare Center is requesting paper compliance.</p>	

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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K010018 SS=D	<p>facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 109 and had a census of 54 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered except for the Main Shower Room and under the exterior canopy by Room 201. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/27/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>						

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K010038 SS=E	<p>Based on observation and interview, the facility failed to ensure 1 of 62 resident sleeping room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:45 a.m. to 2:30 p.m. on 10/17/14, the latching mechanism on the corridor door to Room 202 failed to protrude into the door frame which prevented the door from closing and latching into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the corridor door to Room 202 failed to resist the passage of smoke and had an impediment to closing and latching into the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K010018	<p>1.What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice? Thedeficient practice could affect two residents, staff and visitors. The door wasrepaired by Maintenance Director immediately to Room 202.</p> <p>2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveactions will be taken? Residents, staff and visitors have the potential to beaffected by the deficient practice.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur? The Maintenance Director repaired the door immediately and ensured itssafety. An audit was completed on all resident doors to ensure latching is doneproperly. No other issues were noted.</p> <p>4.How will the corrective actions be monitored toensure the deficient practice will not recur; what quality assurance programwill be put into place? The Maintenance Director/Designee will monitor weeklyx1 for two weeks, then monthly x6, or until 100% compliant through the monthlyQA process for tracking/trending.</p>	11/03/2014

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	<p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 22 residents, staff and visitors if needing to exit the facility by Room 111.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:45 a.m. to 2:30 p.m. on 10/17/14, the exit by Room 111 was marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but</p>	K010038	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The deficient practice could affect 22 residents, staff and visitors. The magnetic door lock was repaired by Maintenance Director immediately.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Residents, staff and visitors have the potential to be affected by the deficient practice.</p> <p>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? An audit was done on all magnetically locked doors. No other deficiencies were found.</p> <p>4.How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? The Maintenance Director/Designee will monitor weekly x1 for two weeks, then monthly x6, or until 100% compliant through the monthly QA process for tracking/trending.</p>	11/03/2014			

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K010056 SS=E	<p>the posted code did not unlock the door when it was entered into the keypad five separate times. Based on interview at the time of observation, the Maintenance Director stated not all residents in the 100 Hall have a clinical diagnosis to be in a secure building and acknowledged the posted four digit code at the facility exit by Room 111 did not unlock the exit door. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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>			

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	<p>1. Based on observation and interview, the facility failed to ensure sprinkler installation in 1 of 1 shower rooms to provide coverage for all portions of the building. This deficient practice could affect 18 residents, staff and visitors in the vicinity of the Main Shower Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:45 a.m. to 2:30 p.m. on 10/17/14, all areas of the Main Shower Room except for the closet were not sprinklered. Based on interview at the time of observation, the Maintenance Director stated the Main Shower Room was recently remodeled which included the addition of a suspended ceiling and acknowledged the aforementioned Main Shower Room was not sprinklered.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>2. Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 3 combustible exterior canopies wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient</p>	K010056	<p>1.What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice? The deficientpractice has the potential to affect 14 residents, staff and visitors. Vendorrepaired/installed the shower heads according to code in the shower rooms on10/30/14. The exterior awning was removed from the facility immediately.</p> <p>2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveactions will be taken? Residents, staff and visitors have the potential to beaffected by the deficient practice.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur? An audit was done on all shower rooms and exterior extensions/canopiesfor compliance. No other deficiencies were found.</p> <p>4.How will the corrective actions be monitored toensure the deficient practice will not recur; what quality assurance programwill be put into place? The Maintenance Director/Designee will monitor weeklyx1 for two weeks, then monthly x6, or until 100% compliant through the monthlyQA process for tracking/trending.</p>	11/03/2014

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K010062 SS=F	<p>practice could affect 14 residents, staff and visitors if needing to exit the facility by Room 201.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:45 a.m. to 2:30 p.m. on 10/17/14, the exterior canopy at the exit by Room 201 extended seven feet from the building, was of fabric construction and was not provided with automatic sprinklers. Based on interview at the time of observation, the Maintenance Director stated documentation was not available for review demonstrating the fabric canopy was noncombustible and acknowledged the aforementioned canopy extended more than four feet from the building, was of combustible construction and was not provided with automatic sprinklers.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested</p>						

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	<p>periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was clear of blockage once an internal pipe inspection revealed obstruction. NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems at 10-2.3 requires a complete flushing program shall be conducted by qualified personnel. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare "Service Call Report" documentation dated 06/04/14 during record review with the Administrator and the Maintenance Director from 9:25 a.m. to 11:45 a.m. on 10/17/14, an internal pipe inspection on 06/04/14 for the facility's dry sprinkler system stated "Perform internal pipe inspection on fire sprinkler systems," "found rust and debris in sprinkler pipe" and "send quote to flush both Tyco fire sprinkler systems." In addition, SafeCare's "Purchase Agreement" dated 07/08/14 stated "This quote is for performing a complete dry pipe sprinkler system hydraulic flush of all sprinkler feed mains, cross mains, and branch lines</p>	K010062	<p>1.What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice? Thedeficient practice has the potential to affect all residents, staff andvisitors. After conversation with vendor, a waiver will be completed byAdministrator/Designee due to increment freezing temperatures to completeproject. As for escutcheon plates, the deficient practice could affect 10residents, staff and visitors. The Maintenance Director immediatelyreplaced/repared all defective escutcheon plates. As for blue cable, thedeficient practice could affect 2 staff and visitors in Laundry. TheMaintenance Director immediately removed the blue cord noted in survey.</p> <p>2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveactions will be taken? All residents, staff and visitors have the potential tobe affected by the deficient practice. As for escutcheon plates, all residents,staff and visitors have the potential to be affected. As for blue cord, twostaff and visitors could be affected.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure</p>	11/03/2014

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	<p>of the entire facility. This includes the fire sprinkler system covering the nursing home along with the system covering the detached laundry building." Based on interview at the time of record review, the Administrator stated a quote has been obtained to perform sprinkler system flushing but acknowledged flushing of the facility's dry sprinkler system has not been scheduled or performed following SafeCare's 06/04/14 internal pipe inspection.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 5 of over 100 sprinkler heads were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:45 a.m. to 2:30 p.m. on 10/17/14, each of the five following automatic sprinkler locations had a missing escutcheon:</p>		<p>that the deficient practice does not recur? Any malfunctions in the sprinkler system will be repaired/replaced immediately by vendor(s) until flushing can be done at the appropriate time of season with vendor. As for escutcheon plates, the Maintenance Director audited all sprinkler heads in facility. No other deficiencies were noted. As for bluecord, Maintenance Director did an audit of facility for sprinkler system supporting non-system components. No other deficiencies were noted.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? The Maintenance Director/Designee will monitor escutcheon plates and non-system components weekly x1 for two weeks, then monthly x6, or until 100% compliant through the monthly QA process for tracking/trending.</p>	

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	<p>a. restroom in the Main Physical Therapy Room</p> <p>b. Dietary Manager's Office</p> <p>c. storage room in the Breakroom</p> <p>d. Activity Director's Office</p> <p>e. the closet in the Main Shower Room</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned automatic sprinklers each had a missing escutcheon.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect 2 staff and visitors in the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:45 a.m. to 2:30 p.m. on</p>			

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K010130 SS=C	<p>10/17/14, a blue cable was wrapped around a twelve foot length of sprinkler pipe near the entrance to the Laundry. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler pipe location was being used to support nonsystem components.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:45 a.m. to 2:30 p.m. on 10/17/14, the fuel fired boiler in the Mechanical Room outside the kitchen had no current Certificate of Inspection</p>	K010130	<p>1.What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice? Thedeficient practice has the potential to affect all residents, staff andvisitors. On 10/27/14, the vendor came and checked for compliance on waterheaters.</p> <p>2.How other residents having the potential to be affectedby the same deficient practice will be identified and what corrective actionswill be taken? All residents, staff and visitors have the potential to beaffected by the deficient practice.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur? An audit was done on both water heaters by vendor and MaintenanceDirector inspected the boiler. No other deficiencies were found.</p>	11/03/2014			

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	documentation from the State of Indiana available for review. A blue tag with State of Indiana registration number 311204 indicating the unit had required previous Certificate of Inspection documentation was affixed to the boiler. Based on interview at the time of observation, the Maintenance Director stated the unit should have current Certificate of Inspection documentation but acknowledged current Certificate of Inspection was not available for review. 3.1-19(b)		4.How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? The Maintenance Director/Designee will monitor the inspection process through the TELS system semiannually. Maintenance Director/Designee will continue to bring reports to the monthly QA process for tracking/trending.		