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 12/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	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). Survey Date: 12/02/15 Facility Number: 000149 Provider Number: 155245 AIM Number: 100266840 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. This one story facility was determined to be of Type V (111) construction and fully sprinklered except for the former telephone room near the central atrium. 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 smoke detectors in all resident sleeping rooms.	K 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Castleton Health Care maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care.Furthermore, Castleton Health Care asserts that it is in substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety constitutes this provider's credible allegation of compliance and, thereby, we request resurvey to verify such as of 12/31/2015. **Further, we request desk review (paper compliance) for compliance, if acceptable. Should additional information be required to complete the request, please advise the undersigned.** Completion dates are provided for procedural	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	The facility has a capacity of 109 and had a census of 45 at the time of this visit. All areas where the residents have customary access were sprinklered except for the former telephone room near the central atrium. All areas providing facility services were spinklered. Quality Review completed on 12/04/15 - DA		processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated or accomplished corrective action. These do not necessarily chronologically correspond to the date that Castleton Health Care is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.	
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to provide 1 of over 100 corridor room doors with not more than one releasing operation. LSC Section 7.2.1.5.4 states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.4 states examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient	K 0038	It is the policy of this provider to have exit access arranged so that exits are readily accessible at all times. *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* No residents were found to have been affected by this alleged deficiency. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* Other residents with the propensity to be affected by the same alleged deficient practice would be identified as none. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does*	12/18/2015

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	practice could affect 20 residents, staff and visitors in the vicinity of the Medical Records Office. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:15 p.m. on 12/02/15, the corridor door to the Medical Records Office has two locks on the door and a key was needed to unlock the deadbolt on the door. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door required more than one releasing operation to open the door. 3-1.19(b)		*not recur?* The additional lock requiring a key was removed from the door. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?*Since the offending deadbolt lock was removed to achieve compliance the deadbolt will not be re-installed. The staff responsible for the installation of the deadbolt is no longer employed at the facility. 5. EDC– 12/18/2015	
K 0052 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure all smoke	K 0052	It is the policy of this provider to maintain the fire detection system in accordance with applicable	12/31/2015

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	detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked); the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity		provisions of NFPA 70 & 72. *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* See item 3. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will betaken?* Other residents with the propensity to be affected by the same alleged deficient practice would be identified as all. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An outside contractor was retained by the provider to test every smoke detector for appropriate calibration and operation. Such testing was completed on 12/11/2015. The employee responsible to schedule the test within NFPA 70&72 parameters is no longer employed by the provider. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?* Since an outside contractor is retained by the provider, and the scheduling is fixed by contract, in 2 years the QAPI committee will remind the maintenance staff to have the testing scheduled, and the contractor is expected to remind the provider as well. 5. EDC–12/11/2015	

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	155245		12/02/2015

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	range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director from 9:00 a.m. to 11:00 a.m. on 12/02/15, documentation of smoke detector sensitivity testing within the most recent two year period was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged sensitivity testing documentation for all facility fire alarm system smoke detectors within the most recent two year period was not available for review. 3.1-19(b)			
K 0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	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			
	1. Based on observation and interview, the facility failed to ensure a sprinkler head was installed in 1 of 1 former telephone rooms to provide coverage for all portions of the building. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the former telephone room near the central atrium. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:15 p.m. on 12/02/15, the former telephone room near the central atrium was not sprinklered. Based on interview at the time of observation, the Maintenance Director acknowledged the former telephone room near the central atrium was not sprinklered.	K 0056	It is the policy of this provider to comply with NFPA 101 as applicable *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* No residents were identified. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* Other residents with the propensity to be affected by the same alleged deficient practice would be identified as none. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* 1.) It should be noted that the facility, identified as a class V building (predominantly non-combustible material construction), was constructed circa 1970 and has been inspected at least annually since	12/31/2015

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	3.1-19(b) 3.1-19(ff) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 5-6.5 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-6.5.2 and 5-6.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect two staff in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:15 p.m. on 12/02/15, two four inch in diameter PVC pipes were installed next to each other and were aligned parallel to the ceiling one inch below the deflector for the one pendent sprinkler in the oxygen storage and transfilling room which caused an obstruction to sprinkler discharge. Based on interview at the time of observation, the Maintenance Director stated the PVC		then, and in point of fact, in some years multiple times. This has never been an issue until this survey. The space is 24" deep by 38" wide. Notwithstanding the aforementioned, an outside contractor certified for sprinkler installation and retrofitting has been contacted to quote and install said sprinkler head. 2.) The contractor who located the pipe near the sprinkler head has been contacted to return and relocate the pipe in an appropriate place so as not to occlude or otherwise block the coverage of the sprinkler head. In addition, the sprinkler contractor will assess whether the sprinkler is able to be relocated in a compliant position *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?*1.) Once installed, the sprinkler head will require no further monitoring. 2.)Once relocated, the pipe will require no further monitoring. The staff member who supervised the installation of the CPVC pipe is no longer employed by the provider. 5.EDC– 12/31/2015	

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	pipes were installed within the last year and acknowledged the aforementioned pendent sprinkler was not positioned to ensure adequate coverage for the entire oxygen storage and transfilling room. 3.1-19(b) 3.1-19(ff)			
K 0062 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to replace 4 of over 100 sprinklers which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 20 residents, staff	K 0062	It is the policy of this provider to continuously maintain the required automatic fire suppression (sprinkler) system per relevant NFPA 13 & 25 sections. *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* Residents of the four rooms cited had the foreign material found on the sprinkler head either removed or the sprinkler head was replaced. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what*	12/31/2015

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	and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:15 p.m. on 12/02/15, the pendent sprinkler installed in the closet for Room 102, 104, 112 and 119 each had white paint covering the glass vial portion of the sprinkler and brown paint on the deflector. Based on interview at the time of the observations, the Maintenance Director acknowledged each of the aforementioned four sprinkler locations had foreign materials on them. 3.1-19(b)		*corrective action will be taken?* Other residents with the propensity to be affected by the same alleged deficient practice would be identified as those with foreign material on the sprinkler heads. None were so identified. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An outside contractor was retained to clean or replace the sprinkler heads in question. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?*Once replaced the sprinkler heads needed no further monitoring. However the QAPI committee will monitor the contractor to assure completion of the work within the time frame or direct the administrator to request a temporary extension until the work can be completed. 5. EDC– 12/31/2015	
K 0064 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 18 portable fire extinguishers had pressure gauge	K 0064	It is the policy of this provider to maintain all portable fire extinguishers in accordance with the relevant sections of NFPA 10	12/31/2015

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	readings in the acceptable range. LSC 4.5.6 requires any fire protection system, building service equipment, feature of protection or safe guard provided for life safety shall be designed, installed and approved in accordance with applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect any two staff in the Laundry. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:15 p.m. on 12/02/15, the pressure gauge on the portable fire extinguisher in the washing machine area of the Laundry showed the fire extinguisher was undercharged. The inspection tag on the portable fire extinguisher listed the most recent annual inspection was in September 2015 and the most recent monthly inspection was in November 2015. Based on interview at the time of observation, the Maintenance Director acknowledged the		*1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* None were so identified. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* Other residents with the propensity to be affected by the same alleged deficient practice would be identified as none. *3. 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 fire extinguisher was removed from service and replaced with a correctly/fully charged extinguisher. *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?*The acting maintenance director was educated by the Interim Executive Director on the importance of the monthly inspection and its documentation.Additionally, a portable extinguisher that is found to be undercharged while inactive service – shall be removed and replaced immediately with a properly charged unit for the safety of all occupants of the enclosed space. The acting maintenance director demonstrated understanding of the importance and comprehension of the steps to	

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	aforementioned portable fire extinguisher pressure gauge indicated the fire extinguisher was undercharged. 3.1-19(b)		complete the task on schedule. A report showing which (if any) of the portable extinguishers were found defective during the inspection will be given to the QAPI committee or its designee for review for a minimum of 4 months, with further monitoring at the direction of the committee. 5.EDC– 12/31/2015	
K 0067 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient	K 0067	It is the policy of this provider to maintain HVAC systems in accordance with NFPA 90A. *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* An outside contractor has been retained to inspect/maintain dampers located in HVAC ductwork in accordance with NFPA 90A(1999 edition). *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will betaken?* Other residents with the propensity to be affected by the same alleged deficient practice would be identified as all. An outside contractor has been retained to inspect/maintain dampers located in HVAC	12/31/2015

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	practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director from 9:00 a.m. to 11:00 a.m. on 12/02/15, documentation of fire damper inspection and maintenance performed within the most recent four year period was not available for review. Based on interview at the time of record review, the Maintenance Director stated fire dampers are installed in the facility, fire damper maintenance should have been scheduled prior to November 2015 and acknowledged documentation of fire damper inspection and maintenance performed within the most recent four year period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:15 p.m. on 12/02/15, a fire damper was located in the Conference Room by the south nurse's station, in the Medical Records Storage Room in the employee lounge and in the Director of Nursing's Office. 3.1-19(b)		ductwork in accordance with NFPA 90A (1999 edition). *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?* An outside contractor has been retained to inspect/maintain dampers located in HVAC ductwork in accordance with NFPA 90A (1999 edition). *4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?*The maintenance director or designee will be responsible to maintain a calendar and working with the outside contractor will assure that such inspections are conducted within the appropriate time frame. A monthly report will be submitted to the QAPI committee outlining inspections and recommendations for the previous month by the maintenance director or designee for review/action/recommendation by the committee. Such reporting will be ongoing. 5.EDC–12/31/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155245		12/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0070 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on record review, observation and interview; the facility failed to ensure portable space heaters were not used in health care occupancies. 19.1.2.1 Sections of health care facilities shall be permitted to be classified as other occupancies if they meet all of the following conditions: (a) They are not intended to serve health care occupants for purposes of housing, treatment, or customary access by patients incapable of self-preservation; (b) They are separated from areas of health care occupancies by construction having a fire resistance rating of at least 2 hours. This deficient practice could affect ten residents, staff and visitors in the vicinity of the Director of Nursing's (DON) Office by the south nurse's station. Findings include: Based on record review with the Maintenance Director from 9:00 a.m. to 11:00 a.m. on 12/02/15, a policy regarding portable space heater use in the	K 0070	It is the policy of this provider to not utilize portable space heaters of any kind. *1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?* No residents were identified. *2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* Other residents with the propensity to be affected by the same alleged deficient practice would be identified as those with portable space heaters. None were so identified. *3. 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 space heater was removed. The employee who utilized the offending appliance is no longer employed by the provider. *4. How will the corrective action be monitored to ensure that the deficient practice does not recur?*During the monthly tour for fire extinguisher inspection, the maintenance director or designee will check office and other areas to assure that no portable space	12/31/2015

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 12/02/2015
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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	facility was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:15 p.m. on 12/02/15, an electric space heater was observed in operation in the Director of Nursing (DON) office by the south nurse's station. The DON ' s office lacked separation with a two hour fire-resistance rating from the south resident dining area as well as from the same smoke compartment in which the DON ' s office was located in. Based on interview at the time of observation, the Maintenance Director stated the DON ' s office was considered business occupancy and was not part of the health care occupancy. Additionally, documentation of the heating element temperature was not available for review and acknowledged a portable space heater was in use in the Director of Nursing's (DON) Office by the south nurse's station. 3.1-19(b)		heaters are in use. This will be part of the monthly report submitted to the QAPI committee by the maintenance director or designee. 5. EDC– 12/31/2015	