PRINTED: 10/18/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155245		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/30/2024		
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COD 7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg	conducted by the In accordance with 42 Survey Date: 09/30 Facility Number: 0 Provider Number: 100 At this Emergency Castleton Health Cacompliance with Endity Requirements for Marticipating Provides 483.73. The facility has 100 the survey, the censure of the survey of the survey of the survey of the requirement at MET as evidenced	00149 155245 266840 Preparedness survey, are Center was found not in mergency Preparedness fledicare and Medicaid ders and Suppliers, 42 CFR 0 certified beds. At the time of rus was 53. 42 CFR, Subpart 483.73 is NOT by:	E 00	000	Preparation and/or execution of this plan of correction does not constitute admission or agreer set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed because it is require the provisions of federal and so law. Castleton Healthcare Cerasserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and the this Plan of Correction in its entirety constitutes the provided credible allegation of compliant and respectfully is requesting paper compliance on review.	t ment d by tate nter	
E 0004 SS=F Bldg	403.748(a), 416.5 Develop EP Plan, Annually Based on record rev failed to maintain 1 plans that were revi annually in accorda	A(a), 418.113(a), 441.1 Review and Update View and interview, the facility of 1 emergency preparedness ewed and updated at least nee with 42 CFR 483.73(a). ice could affect all occupants.	E 00	004	E004 General Requirements – The emergency preparedness plar been reviewed and updated as necessary by the facility IDT team. An AD-HOC QAPI was	n has s	10/14/2024

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

Based on review of "Emergency Preparedness

Findings include:

TITLE

the start of each calendar year.

on 10.7.2024 for annual review and will be held annually thereafter at

(X6) DATE

William McCallum Regional Director of Ops 10/14/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 14J421 Facility ID: 000149 If continuation sheet Page 1 of 20

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

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i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	COMPLETED	
		155245	B. W	B. WING 09/30/2024			2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7630 E 86TH ST INDIANAPOLIS, IN 46256					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		T	ID		I		
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I E	DATE	
	Maintenance Direct 9:30 a.m. to 12:10 preparedness prograreviewed within the period was not avail interview at the time Maintenance Direct documentation was emergency prepared Administrator's copat the time of the su preparedness progradocumented as bein recent twelve month.	on dated 05/24/22 with the or during record review from o.m. on 09/30/24, emergency am documentation which was most recent twelve month lable for review. Based on e of record review, the or stated the 05/24/22 the nurse's station version of liness documentation, the y was not available for review revey and agreed emergency am documentation was not g reviewed within the most in period.			Facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024 Method to Assess: The facility administrator and director of properations have reviewed all facility copies to ensure accurate and review of EP plan has been completed. Systematic Process: Quality Assurance Executive Director/Designee will present results of any visual inspection the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	ty lant acy en		
E 0006 SS=F Bldg	Plan Based on All Based on record rev failed to maintain ar plan that was (1) ba documented, facility risk assessment, util which was reviewed month period and (2 addressing emergen risk assessment in a 483.73(a) (1) and 42	416.54(a)(1)-(2), 418 Hazards Risk Assessment iew and interview, the facility n emergency preparedness sed on and includes a y-based and community-based izing an all-hazards approach it within the most recent twelve included strategies for cy events identified by the ccordance with 42 CFR 2 CFR 483.73(a) (2). This build affect all occupants.	E 00	006	E006 General Requirements – The facility IDT completed an annufacility/community-based haza vulnerability assessment for the calendar year of 2024. The ID continue to monitor this assessment for any necessary changes related to the facility and/or community. Facility has completed onsite inspection by the requirement, with Compliandate of 10.14.2024	al rd ee T will ,	10/14/2024	

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Event ID:

14J421

Facility ID: 000149

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING		COMPL	
		155245	B. WING 09/30/2024				/2024
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7630 E 86TH ST INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0013 SS=F Bldg	Based on review of Book" documentation Maintenance Direct 9:30 a.m. to 12:10 processes facility-based and considerable for review available for review time of record review stated the 05/24/22 station version of endocumentation, the available for review agreed a documentation of the facility within the period was not available for review agreed and community-based of the facility within the period was not available for review agreed and community-based of the facility within the period was not available for review agreed and community-based of the facility within the period was not available for review agreed and community-based of the facility within the period was not available for review agreed and community-based of the facility within the period was not available for review agreed and community-based of the facility within the period was not available.	"Emergency Preparedness on dated 05/24/22 with the for during record review from o.m. on 09/30/24, a documented community-based risk d by the facility within the month period was not a. Based on interview at the few, the Maintenance Director documentation was the nurse's mergency preparedness. Administrator's copy was not at the time of the survey and a facility-based and lisk assessment reviewed by the most recent twelve month.			Method to Assess: The facili administrator and Director of poperations have reviewed all facility copies to ensure accurs of facility and hazards vulneral plan. Systematic Process: Quality Assurance Executive Director/Designee will present results of any visual inspection the QAPI committee for further ecommendations and will continue until QAPI team determines substantial compliance has been achieved.	olant acy bility	
Diug	failed to review and preparedness policiprocedures must be annually in accorda This deficient pract. Findings include: Based on review of Book" documentating Maintenance Direct 9:30 a.m. to 12:10 preparedness policies.	riew and interview, the facility lupdate its emergency es annually. The policies and reviewed and updated at least nce with 42 CFR 483.73(b). ice could affect all occupants. "Emergency Preparedness on dated 05/24/22 with the for during record review from o.m. on 09/30/24, emergency es and procedures reviewed ent twelve month period was	E 00	013	E013 General Requirements – The emergency preparedness plan been reviewed and updated at necessary by the facility IDT team. An AD-HOC QAPI was on 10.7.2024 for annual review will be held annually thereafte the start of each calendar year Facility has completed onsite inspection by the requirement, with Compliance date of 10.14.2024 Method to Assess: The facility	n has s held w and r at r.	10/14/2024

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155245		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/30/2024	
	PROVIDER OR SUPPLIEF		7630 E	ADDRESS, CITY, STATE, ZIP COD 86TH ST NAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	time of record revies stated the 05/24/22 station version of el documentation, the available for review agreed emergency procedures reviewe twelve month period. These findings were	view. Based on interview at the tw, the Maintenance Director documentation was the nurse's mergency preparedness. Administrator's copy was not at the time of the survey and preparedness policies and d within the most recent d was not available for review.		administrator and Director of operations have reviewed all facility copies to ensure accur of facility and hazards vulnerary plan. Systematic Process: Quality Assurance Executive Director/Designee will present results of any visual inspection the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	racy ability t n to er
E 0029 SS=F Bldg	Based on record reversities failed to develop and preparedness common with Federal, State, reviewed and update accordance with 42 practice could affect Findings include: Based on review of Book" documentating Maintenance Direct 9:30 a.m. to 12:10 program for a complete emerging the same and the same an	"Emergency Preparedness on dated 05/24/22 with the for during record review from o.m. on 09/30/24, documentation regency preparedness	E 0029	E029 General Requirements – The emergency preparedness "communication" plan has bee reviewed and updated as necessary by the facility IDT team. An AD-HOC QAPI was on 10.7.2024 for annual revie will be held annually thereafte the start of each calendar year Facility has completed onsite inspection by the requirement with Compliance date of 10.14.2024	held w and er at ar.
	within the most rec	n reviewed by the facility ent twelve month period was view. Based on interview at the		Method to Assess: The facil administrator and Director of operations have reviewed all	-

time of record review, the Maintenance Director

operations have reviewed all

facility copies to ensure accuracy

	WIEDICAKE & WIEDIC				OMB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155245	B. WING		09/30/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7630 E 86TH ST INDIANAPOLIS, IN 46256				
	Ι			·	<u> </u>		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG		Ditte		
		documentation was the nurse's		of facility and hazards vulneral	oility		
		mergency preparedness		plan.			
		Administrator's copy was not					
		v at the time of the survey and		Systematic Process: Quality			
	agreed documentati	ion for a complete emergency		Assurance Executive			
	preparedness comm	nunication plan reviewed by		Director/Designee will present			
	the facility within the	he most recent twelve month		results of any visual inspection	to		
	period was not avai	lable for review.		the QAPI committee for further			
				recommendations and will			
These findings were not reviewed with the			continue until QAPI team				
	Maintenance Direct	tor during the exit conference.		determines substantial			
				compliance has been achieved	d.		
E 0036 SS=F Bldg	EP Training and T Based on record rev failed to develop an preparedness trainin was reviewed and u	view and interview, the facility and maintain emergency and testing program that updated at least annually in CFR 483.73(d). This deficient	E 0036	E036 General Requirements – The emergency preparedness "Tes plan has been reviewed and updated as necessary by the facility IDT team. An AD-HOC QAPI was held for annual revie and will be held annually there	ew		
	Book" documentati	"Emergency Preparedness on dated 05/24/22 with the		at the start of each calendar ye Facility has completed onsite inspection by the requirement,			
		tor during record review from		with Compliance date of			
		o.m. on 09/30/24, the facility's		10.14.2024			
		dness training and testing					
		ation was not reviewed within		Method to Assess: The facilit	· I		
		lve month period. Based on		administrator and Director of p	lant		
		e of record review, the		operations have reviewed all			
	Maintenance Direct	tor stated the 05/24/22		facility copies to ensure accura	асу		
		the nurse's station version of		of facility training and testing p	lan		
	emergency prepared	dness documentation, the		as well as education for existing	g		
	Administrator's cop	y was not available for review		employee and new hire educa	-		

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at the time of the survey and agreed the facility's

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within orientation. All employees

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETE			ETED	
		155245	B. WING 09/30/2024				
					_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
0407157	FON LIE AL TILLOAD	E OENTED			86TH ST		
CASTLET	TON HEALTH CAR	E CENTER		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	emergency prepared	lness training and testing			are assigned virtual education		
	program documentation was not reviewed within the most recent twelve month period.				annually that will aid and assis	t in	
					the development of training pla	an.	
					-		
	These findings were	e not reviewed with the			Systematic Process: Quality		
	Maintenance Direct	or during the exit conference.			Assurance Executive		
					Director/Designee will present		
					results of any visual inspection		
				the QAPI committee for further			
				recommendations and will			
					continue until QAPI team		
				determines substantial			
				compliance has been achieved	d.		
E 0037		6.54(d)(1), 418.113(d)(
SS=F	EP Training Progr	am					
Bldg							
		riew and interview, the facility	E 00)37	<u>E037</u>		10/14/2024
		emergency preparedness			General Requirements – The		
		program includes a training			emergency preparedness "trai	ning	
		facility must do all of the			and testing" plan has been		
		training in emergency			reviewed and updated as		
		es and procedures to all new			necessary by the facility IDT		
	and existing staff, in	ndividuals providing services			team. An AD-HOC QAPI was I	held	
	under arrangement,	and volunteers, consistent			on 10.7.2024 for annual reviev	v and	
	with their expected	roles; (ii) Provide emergency			will be held annually thereafter	r at	
	preparedness trainin	g at least annually; (iii)			the start of each calendar year	r.	
	Maintain documenta	ation of the training; (iv)			Facility has completed onsite		
	Demonstrate staff k	nowledge of emergency			inspection by the requirement,		
	procedures in accor-	dance with 42 CFR 483.73(d)			with Compliance date of		
	(1). This deficient p	practice could affect all			10.14.2024		
	occupants.						
					The facility has implemented t	the	
	Findings include:				following:		
	Based on review of "Emergency Preparedness				IDT completed a table-top	0	,
		on dated 05/24/22 with the			exercise on 10.7.2024 (active		
		or during record review from			Shooter)		

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Event ID:

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Facility ID: 000149

If continuation sheet

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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
11.21211	201112011011	155245	B. WING		09/30/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7630 E 86TH ST INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR 9:30 a.m. to 12:10 p for staff training on within the most reconstrained of record revies stated the 05/24/22 station version of endocumentation, the available for review agreed annual staff emergency prepared within the most reconstrained and available for review agreed annual staff emergency prepared within the most reconstrained and available for review agreed annual staff emergency prepared within the most reconstrained and available for review agreed annual staff emergency prepared within the most reconstrained and available for review agreed annual staff emergency prepared within the most reconstrained and available for review agreed annual staff emergency prepared within the most reconstrained and available for review agreed annual staff emergency prepared within the most reconstrained and available for review agreed annual staff emergency prepared within the most reconstrained and available for review agreed annual staff emergency prepared within the most reconstrained and available for review agreed annual staff emergency prepared within the most reconstrained a	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION O.m. on 09/30/24, documentation emergency preparedness ent twelve month period was view. Based on interview at the w, the Maintenance Director documentation was the nurse's mergency preparedness Administrator's copy was not vat the time of the survey and training documentation on the elness program conducted ent twelve month period was view. The not reviewed with the or during the exit conference.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIL DEFICIENCY) Implemented EP training review on orientation Assigned routine training all existing employees via electronic education platform. Method to Assess: The Fact Administrator and Director of operations have reviewed all facility copies to ensure accur of facility and hazards vulneral plan. Systematic Process: Quality Assurance Executive Director/Designee will present results of any visual inspection the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	g and g for illity Plant racy ability t n to		
K 0000 Bldg. 01			K 0000	Preparation and/or execution this plan of correction does not constitute admission or agrees set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed because it is require the provisions of federal and law. Castleton Healthcare Ce	ot ment of ed by state		

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155245	B. W	ING		09/30/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹					
CASTLE	TON HEALTH CAR	E CENTED	7630 E 86TH ST INDIANAPOLIS, IN 46256				
CASTLL	TONTILALITICAN	L CLIVILIX		INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					asserts that it is in substantial		
		Code survey, Castleton Health			compliance with regulations		
	Care Center was for	und not in compliance with			governing the operation of		
	Requirements for P	articipation in			long-term care facilities, and the	nat	
	Medicare/Medicaid	, 42 CFR Subpart 483.90(a),			this Plan of Correction in its		
	Life Safety from Fi	re and the 2012 edition of the			entirety constitutes the provide	ers	
	National Fire Protect	ction Association (NFPA) 101,			credible allegation of compliar	nce	
	Life Safety Code (I	LSC), Chapter 19, Existing			and respectfully is requesting		
	Health Care Occupancies and 410 IAC 16.2.				paper compliance on review.		
	This one story facil	ity was determined to be of					
	Type V (111) const	ruction and fully sprinklered.					
	The facility has a fi	re alarm system with smoke					
	detection in the cor	ridors and in all areas open to					
	the corridor. The fa	acility has battery operated					
	smoke detectors in	all resident sleeping rooms.					
	The facility has a ca	apacity of 109 and had a					
	census of 53 at the	time of this visit.					
	A 11 1 41	.1 . 1					
		residents have customary					
	_	ered and all areas providing					
	facility services we	re sprinklered.					
	Quality Review cor	mpleted on 10/02/24					
K 0271	NFPA 101						
SS=E	Discharge from Ex	xits					
Bldg. 01	D 1 1 2	11.4			1/0=/		10/11/2001
		on and interview, the facility	K 0	271	<u>K271</u>		10/14/2024
		f 8 exit discharges was			General Requirements – The		
	-	ained free of all obstructions			identified bicycle lock was		
	_	full instant use in the case of			removed from the fenced area	Ι,	
	_	ency. This deficient practice			with the area being free from		
		residents, staff and visitors if			obstruction or impediments to	TUII	
		facility from the dining room			instant use. Facility has		
	near the center lobb	py.			completed onsite inspection p		
	Findings include:				requirement, with Compliance	date	
					of 10.14.2024		
	Based on observation	ons with the Maintenance			Method to Assess: The direct	tor	

10/18/2024 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED B. WING 09/30/2024 155245 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7630 E 86TH ST CASTLETON HEALTH CARE CENTER INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Director during a tour of the facility from 12:25 of plant operations visually p.m. to 2:00 p.m. on 09/30/24, the exit door which inspected all areas of exit, lead to the outside of the facility for the dining including courtyards and fenced room was marked as a facility exit with an exit sign. areas to ensure no other The door was magnetically locked and could be obstructions/impediments were opened by entering a code into a keypad at the identified or out of compliance exit door. The correct code to release the exit door related to inspection. to open was posted at the exit door. The exit discharge for the dining room exit was in a fenced Systematic Process: Quality in area and had one gate in the fence which led to Assurance Executive the public way. The gate was locked with bicycle Director/Designee will present lock wrapped through the chain link fence and results of any visual inspection to gate. The bicycle lock was a combination lock the QAPI committee for further with the combination not posted on or near the recommendations and will lock. Based on interview at the time of the continue until QAPI team observations, the Maintenance Director stated determines substantial only staff knew the combination to release the compliance has been achieved. bicycle lock and agreed the aforementioned exit discharge was not free of obstruction or impediments to full instant use. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)

K 0291 SS=F Bldg. 01

NFPA 101

Emergency Lighting

interview; the facility failed to document monthly testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).

Based on record review, observation and

K 0291

K291 General Requirements -

Functional testing was completed for all battery powered backup lights. Facility has completed onsite inspection per requirement, with Compliance date of 10.14.2024. All testing will be on-going every 30 days thereafter. 10/14/2024

Method to Assess: The director

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155245		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/30/2024			
NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CAR		STREET ADDRESS, CITY, STATE, ZIP COD 7630 E 86TH ST INDIANAPOLIS, IN 46256					
PREFIX (EACH DEFICIEN TAG REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
extended beyond 30 authority having jur (3) Functional testin for a minimum of 1 lighting system is be (4) The emergency	g shall be conducted annually 1/2 hours if the emergency		of plant operations visually inspected all battery powered backup lights to ensure requirement is maintained. Systematic Process: Quality Assurance Executive Director/Designee will presen	,			
7.9.3.1.1(1) and (3). (5) Written records shall be kept by the authority having jur	of visual inspections and tests owner for inspection by the		results of any visual inspection the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	n to er			
"Emergency Lightin functional test" document twelve month Director during reconsisted and through August 202 Based on interview the Maintenance Director of functional testing TELS and he complete six month period August 2024 but he report in TELS becans "retired". The Macannot change or up report in TELS for be monthly battery oped documentation for Macanot availate observations with the	Direct Supply TELS Logbook ag: Conduct a 30 second amentation for the most a period with the Maintenance ord review from 9:30 a.m. to 1/24, monthly battery operated entation for March 2024 4 was not available for review. The time of record review, rector stated the monthly task is automatically assigned by the detect and the time of record review, and the time of record review, rector stated the monthly task is automatically assigned by the detect battery light testing for all of March 2024 through cannot generate a completed antenance Director stated he date the ability to generate a pattery light testing and agreed rated light testing and agreed rated light testing March 2024 through August ble for review. Based on the Maintenance Director facility from 12:25 p.m. to 2:00						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	01	COMPLETED		
		155245	B. WING 09/30/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0321 SS=E Bldg. 01	light locations in the located inside the mautomatic transfer semergency generated outside the facility and Each battery operatives test button. These findings were Maintenance Direct 3.1-19(b) NFPA 101 Hazardous Areas Based on observation	e reviewed with the or during the exit conference.	K 0321	<u>K321</u> General Requirements – The	10/14/2024	
	as trash collection r were separated from resistant partitions a closing or automatic 7.2.1.8. This defici residents, staff and room. Findings include: Based on observatic Director during a to p.m. to 2:00 p.m. or capacity portable tra the kitchen. The en the main dining roo closing device and I failed to fully self c frame when tested t on interview at the	ooms (exceeding 64 gallons) n other spaces by smoke and doors. Doors shall be self to closing in accordance with tent practice could affect over 10 visitors in the main dining ons with the Maintenance tur of the facility from 12:25 to 109/30/24, over two 32 gallon try door to the kitchen from m was equipped with a self tatching hardware but the door lose and latch into the door to close multiple times. Based time of the observations, the tor agreed the aforementioned		identified Kitchen door was inspected, repaired and audite appropriate latching/closing mechanisms, the door function as properly. The identified point trash containers were removed from the Dietary area of the building immediately. The fact has completed onsite inspectibly the requirement, with Compliance date of 10.14.202. Method to Assess: The direct plant operations visually inspectable all self-closing doors within the facility to ensure that all latching mechanisms functioned propers.	ed for ins rtable ed ility ion 24 or of ected e ing	

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							RM APPROVED
							IB NO. 0938-039
					ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION			JILDING	<u>01</u>	COMPI	
STATEMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER (X4) ID PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION hazardous area was not separated from other spaces by smoke resistant partitions and doors due to the kitchen door not self closing and latching into the door frame. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b) K 0341 SS=F Bldg. 01 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 10.5.5.1 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall be identified as FIRE ALARM CIRCUIT. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. Section 10.5.5.4 states an	B. W	ING		09/30/2024			
NAME OF I	DDOVIDED OD SLIDDI IEI			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	C		7630 E	86TH ST		
CASTLE	TON HEALTH CAR	E CENTER		INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	hazardous area was	not separated from other			Systematic Process: Quality		
	spaces by smoke re	sistant partitions and doors			Assurance Executive		
	due to the kitchen d	loor not self closing and			Director/Designee will present		
	latching into the do	or frame.			results of any visual inspectior	ı to	
					the QAPI committee for further	r	
	These findings wer	e reviewed with the			recommendations and will		
	Maintenance Direct	tor during the exit conference.			continue until QAPI team		
					determines substantial		
	3.1-19(b)				compliance has been achieved	d.	
SS=F		n - Installation					
Bldg. 01							
			K 0	341	<u>K341</u>		10/14/2024
					General Requirements – The		
					identified electrical room door	was	
	_				immediately locked and		
					inspected. The identified elect	rical	
		-			panel housing the fire alarm		
					breaker was locked and		
					inspected. The Director of Plan		
					operations and dietary director	ſ	
					were educated on authorized		
		_			personnel access only per		
	_	-			requirement. The facility has		
					completed onsite inspection by		
	-	ive device of suitable current			the requirement, with Complia	nce	
		nd capable of interrupting the			date of 10.14.2024		
		cuit current to which it may be					
		vided in each ungrounded			Method to Assess: The direct	tor	
		licated branch circuit(s) and			of plant operations visually		
		e protected against physical			inspected all breaker boxes wi	thin	
	_	eient practice could affect all			the facility to ensure that all		
	residents, staff and	visitors.			latching and lock mechanisms		1

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Findings include:

Based on observations with the Maintenance

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functioned properly.

Assurance Executive

Systematic Process: Quality

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155245	B. WING 09/30/2024			2024	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7630 E 86TH ST INDIANAPOLIS, IN 46256				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	p.m. to 2:00 p.m. or alarm system breakd in the electrical roon restricted to authorize door to the room wat door handle but the the electrical panel in nor the fire alarm brinterview at the time Maintenance Direct	ur of the facility from 12:25 a 109/30/24, access to the fire er located in the electrical panel m in the kitchen was not zed personnel. The entrance as equipped with a lock on the door was not locked. Neither thousing the fire alarm breaker reaker was locked. Based on the of the observations, the or agreed access to the fire er was not restricted to the contract of the contract			Director/Designee will present results of any visual inspection the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved	n to r	
K 0345 SS=F Bldg. 01	failed to maintain 1 accordance with NF Code as required by 9.6. NFPA 72, Sect otherwise permitted shall be performed is schedules in Table 1 by the authority hav states that the followinspected semi-annua. Control unit troub. Remote annuncia c. Initiating devices fire alarm boxes, he etc.) d. Notification applie. Magnetic hold-op	riew and interview, the facility of 1 fire alarm systems in PA 72, National Fire Alarm LSC Sections 19.3.4.5.1 and ion 14.3.1 states that unless by 14.3.2, visual inspections in accordance with the 14.3.1, or more often if required ring jurisdiction. Table 14.3.1 wing must be visually nally: ble signals tors (e.g. duct detectors, manual at detectors, smoke detectors,	K 0.	345	K345 General Requirements – The identified fire alarm system inspection has been provided a supporting documentation and scheduled as semi-annual. All documentation will be kept for record keeping per requirement The Director of Plant operation was educated on system inspection and record keeping The facility has completed ons inspection by the requirement, with Compliance date of 10.14.2024 Method to Assess: The direct of plant operations visually inspected all fire alarm system for function within the facility to ensure function per requireme	nt. ns ite tor s	10/14/2024

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED			
		155245	B. WING 09/30/2024					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7630 E 86TH ST INDIANAPOLIS, IN 46256					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		1	ID	DE OVEDENIA DE LA CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i L	DATE	
	Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm System Inspection" documentation dated 09/11/23 and "Fire Alarm System Inspection" documentation dated 09/06/24 with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 09/30/24, visual semi-annual fire alarm system inspection documentation six months after 09/11/23 was not available for review. Based on interview at the time of record review, the Maintenance Director agreed visual semi-annual inspection documentation for the facility's fire alarm system six months after 09/11/23 was not available for review. These findings were reviewed with the Maintenance Director during the exit conference.				Systematic Process: Quality Assurance Executive Director/Designee will present results of any visual inspectior the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved	n to r		
K 0353 SS=F	NFPA 101 Sprinkler System -	· Maintenance and Testing						
Bldg. 01	facility failed to pro other evidence the s had been inspected. Sprinkler systems sl accordance with NF Inspection, Testing, Water-Based Fire P Edition. NFPA 25, waterflow alarm de- quarterly to verify the damage. NFPA 25, mechanical waterflo- not limited to, water	review and interview, the vide written documentation or prinkler system components and tested for 1 of 4 quarters. In the properly maintained in PA 25, Standard for the and Maintenance of rotection Systems, 2011 Section 5.2.5 requires that vices shall be inspected they are free of physical Section 5.3.3.1 requires the low alarm devices including, but a motor gongs, shall be tested 5, Section 4.3.1 requires records	K 03	353	K353 General Requirements – The identified sprinkler system inspection has been renewed scheduled quarterly per requirement. The Director of Poperations was educated on system inspection and record keeping. The facility has completed onsite inspection by the requirement, with Complia date of 10.14.2024. The identification data cables were raised off an secured above the sprinkler picorrecting the identified	and Plant y nce fied d	10/14/2024	

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STATEMENT OF DEFICIENCIES X1) PROVIDER		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	LETED
		155245	B. W	'ING		09/30/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			86TH ST		
CASTLE	TON HEALTH CAR	E CENTER		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		l inspections, tests, and			observation.		
		system components and shall					
		o the authority having			Method to Assess: The direct	ctor	
		quest. NFPA, 25 Section 4.3.2			of plant operations visually		
	-	s shall indicate the procedure			inspected all fire alarm system		
		pection, test, or maintenance),			for function within the facility to		
	_	t performed the work, the This deficient practice could			ensure function per requireme		
		staff and visitors in the facility.			The director of plant operation	15	
	arrect air resideills,	starr and visitors in the facility.			assessed the attic space and corrected any identified conce	ırn	
	Findings include:				related to	:111	
	Findings include.				Telated to		
	Based on review of the sprinkler system				Systematic Process: Quality		
		or's "Sprinkler: Report of			Assurance Executive		
	-	entation dated 12/06/23,			Director/Designee will present	t	
	-	/24 with the Maintenance			results of any visual inspection to		
	Director during reco	ord review from 9:30 a.m. to			the QAPI committee for furthe		
	12:10 p.m. on 09/30	0/24, no second quarter (April,			recommendations and will		
	May, June) 2024 sp	rinkler system inspection			continue until QAPI team		
	documentation was	available for review. Based			determines substantial		
	on interview at the	time of record review, the			compliance has been achieve	d.	
	Maintenance Direct	or stated the sprinkler system					
	inspection contracto	or was revising their					
	-	ng contract with the facility					
		uarter 2024 and agreed it had					
		days in between quarterly					
	*	spection and testing on					
	03/11/24 and 09/06/24.						
	These findings were	e reviewed with the					
	_						
	Maintenance Director during the exit conference.						
	3.1-19(b)						
	2 Rosed on observe	ation and interview, the facility					
		of 1 sprinkler systems in					
		SC 9.7.5. LSC 9.7.5 requires all					
		systems shall be inspected					
	•	ccordance with NFPA 25,					
Standard for the Inspection, Testing, and			1		I		I

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039			
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED 09/30/2024				
		155245	B. W	ING	_					
			STREET ADDRESS, CITY, STATE, ZIP COD							
NAME OF I	NAME OF PROVIDER OR SUPPLIER			7630 E 86TH ST						
CASTLE	TON HEALTH CAR	E CENTER	_	INDIAN	APOLIS, IN 46256					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)			
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE			
		ter-Based Fire Protection								
		5, 2011 edition, Section 5.2.2.2								
		iping shall not be subjected to								
	-	aterials either resting on the								
		he pipe. This deficient practice								
		residents, staff and visitors in								
	the vicinity of resid	ent sleeping Room 121.								
	Findings include:									
	Based on observations with the Maintenance Director during a tour of the facility from 12:25 p.m. to 2:00 p.m. on 09/30/24, data cables were resting on two separate sections of horizontal sprinkler piping in the attic above the corridor outside resident sleeping Room 121 as observed from the attic access door near the exit door to the outside of the facility. Based on interview at the time of the observations, the Maintenance Director agreed sprinkler piping in the attic was subjected to external loads by materials resting on the pipe.									
		e reviewed with the tor during the exit conference								
	3.1-19(b)									
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors									
Š	failed to ensure 1 or resist the passage or practice could affect	on and interview, the facility f over 60 corridor doors would f smoke. This deficient at over 10 residents, staff and tity of the Community Room by soom 220.	K 0	363	K363 General Requirements – The identified "half inch hole" has be repaired above the door handle the community room per requirement. The Director of Forerations was educated on	e of	10/14/2024			

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Findings include:

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corridor doors, smoke passage, and fire protection. The facility has

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155245		A. BUILDING <u>01</u> B. WING		COMPLETED 09/30/2024		
		100240						
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD 86TH ST			
CASTLE	TON HEALTH CAR	E CENTER			IAPOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION ons with the Maintenance		TAG	completed onsite inspection b		DATE	
		ur of the facility from 12:25			the requirement, with Complia	•		
	_	n 09/30/24, the corridor door to			date of 10.14.2024	1100		
		om by resident sleeping Room						
	220 had a one half i	nch diameter hole in the door			Method to Assess: The direct	tor:		
		e door handle which would			of plant operations visually			
		ge of smoke. Based on			inspected smoke passage dod			
		e of the observations, the			for function/repair within the fa	-		
		or agreed the aforementioned I not resist the passage of			to ensure appropriate function requirement.	per		
	smoke.	not resist the passage of			requirement.			
	sinone.				Systematic Process: Quality			
	These findings were	e reviewed with the			Assurance Executive			
	Maintenance Direct	or during the exit conference.			Director/Designee will present	;		
					results of any visual inspection			
	3.1-19(b)				the QAPI committee for furthe	r		
					recommendations and will			
					continue until QAPI team			
					determines substantial compliance has been achieve	d		
					Compliance has been achieved	u.		
14.0704								
K 0761	NFPA 101							
SS=F Bldg. 01	Maintenance, Insp	pection & Testing - Doors						
Diag. 01	Based on record rev	riew, observation and	K 0	761	 <u>K761</u>		10/14/2024	
		ty failed to ensure annual	KU	701	General Requirements – An		10/14/2024	
		ng of all fire door assemblies			annual inspection was comple	ted		
	•	accordance of LSC 19.1.1.4.1.1.			on 10.11.2024 and identified a			
	Communicating openings in dividing fire barriers				annual fire inspection doors fro	om		
	required by 19.1.1.4.1 shall be permitted only in				the annual 2023 report. The			
		be protected by approved			Director of Plant operations wa			
	self-closing fire door assemblies. (See also Section				educated on annual inspection			
	· ·	penings required to have a fire			and record keeping. The facilit	-		
		Table 8.3.4.2 shall be red, listed, labeled fire door			has completed onsite inspection	on		
		window assemblies and their			by the requirement, with Compliance date of 10.14.202	·/		
		ware, including all frames,			Oumphanice date of 10.14.202	-		
	closing devices, and				Method to Assess: The direct	tor		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155245		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/30/2024				
NAME OF I	PROVIDER OR SUPPLIEI	R		STREET ADDRESS, CITY, STATE, ZIP COD 7630 E 86TH ST						
CASTLETON HEALTH CARE CENTER			INDIANAPOLIS, IN 46256							
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION			
TAG	_	R LSC IDENTIFYING INFORMATION e requirements of NFPA 80,		TAG	of plant operations visually		DATE			
		Poors and Other Opening			inspected smoke passage do	ors				
		as otherwise specified in this			for function/repair within the fa					
	Code. NFPA 80 5.	2.1 states fire door assemblies			to ensure appropriate function	-				
	shall be inspected a	and tested not less than			requirement.	•				
	annually, and a wri	tten record of the inspection								
		kept for inspection by the			Systematic Process: Quality					
		2.4.1 states fire door assemblies			Assurance Executive					
		spected from both sides to			Director/Designee will presen					
	assess the overall c	ondition of door assembly.			results of any visual inspectio					
	NFPA 80, 5.2.4.2 states as a minimum, the				the QAPI committee for further	r				
					recommendations and will					
	following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame.				continue until QAPI team determines substantial					
					compliance has been achieve	Ч				
		light frames, and glazing beads			compliance has been achieve	u.				
		rely fastened in place, if so								
	equipped.	1 ,								
		e, hinges, hardware, and								
	noncombustible thr	reshold are secured, aligned,								
	and in working ord	er with no visible signs of								
	damage.									
	(4) No parts are mi									
	` '	s do not exceed clearances								
	listed in 4.8.4 and 6									
		g device is operational; that is,								
		npletely closes when operated								
	from the full open j	is installed, the inactive leaf								
	closes before the ac									
		are operates and secures the								
	door when it is in the	-								
		vare items that interfere or								
		are not installed on the door or								
	frame.									
	(10) No field modif	fications to the door assembly								
	have been performe	ed that void the label.								
		edge seals, where required, are								
		their presence and integrity.								
	This deficient pract	tice could affect all residents,					1			

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155245		ľ í	ILDING	01	COMPL 09/30/	ETED	
NAME OF P	ROVIDER OR SUPPLIER				.DDRESS, CITY, STATE, ZIP COD 86TH ST		
CASTLETON HEALTH CARE CENTER					APOLIS, IN 46256		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL]	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION
TAG	staff and visitors.	LSC IDENTIFYING INFORMATION		TAG	BEITELEXCIT		DATE
	Findings include:						
	Based on review of contractor's "Swing documentation date Maintenance Direct 9:30 a.m. to 12:10 p inspection document twelve month period in the facility. The documentation only in the two corridor of identified as "(3A) a Review of the fire door inspection documentation which was more that the facility has addicentral supply room at the fire rated atticeach resident sleeping interview at the time Maintenance Direct inspection document twelve month period Based on observation Director during a top.m. to 2:00 p.m. or the central supply rorating label affixed indicating it was rat storage room inside fire resistance rating of the door indicating resistance rating. Frand eight 'E' type on	-					
		with a 90-minute fire					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

14J421

Facility ID: 000149

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

PRINTED: 10/18/2024 FORM APPROVED OMB NO. 0938-039

	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ′			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155245	A. BUILD B. WING	A. BUILDING <u>01</u> B. WING			COMPLETED 09/30/2024	
NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 7630 E 86TH ST INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD B		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	(X5) COMPLETION DATE	
	These findings were Maintenance Direct 3.1-19(b)	e reviewed with the or during the exit conference.						

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