STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155245	A. BUILDING -- B. WING	10/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/30/23 Facility Number: 000149 Provider Number: 155245 AIM Number: 100266840 At this Emergency Preparedness survey, Castleton Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 109 certified beds. At the time of the survey, the census was 43. Quality Review completed on 11/02/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/30/23 Facility Number: 000149 Provider Number: 155245 AIM Number: 100266840 At this Life Safety Code survey, Castleton Health	K 0000	Preparation and/or 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ryan Kinzie	Executive Director	11/16/2023

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	Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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. 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. The facility has a capacity of 109 and had a census of 43 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 11/02/23		Health Care Center maintains the alleged deficiencies do not individually jeopardize the health and/or 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 Center 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 the provider's credible allegation of compliance.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.			

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	Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 11 hazardous areas, such as a Central Supply room; a storage room of combustible supplies over 50 square feet in size, was not obstructed from closing. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. LSC 7.2.1.8.1 states a door leaf normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. This deficient practice could affect 10 residents and staff in the vicinity of Central Supply. Findings include: Based on observation during a tour of the facility with Maintenance Director on 10/30/23 from 12:45 p.m. to 2:00 p.m., the corridor door to the central supply room was self-closing but the door was propped open with a rubber door wedge. The Central Supply room, located next to Medical	K 0321	**The facility respectfully requests a desk review in lieu of a post survey revisit for the survey conducted on 10/30/23.** **K321** **Immediate Corrective Action** The wedge that was holding open the central supply room door was removed on 10/30/2023. **Method to Assess Others** The Maintenance Director, or designee, performed documented inspections on 10/30/2023 of all other doors to hazardous areas to ensure no other door was held open, except by a magnetic lock tied to the fire alarm system. All	11/16/2023

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	Records, is over 50 square feet and contained combustible supplies. Based on interview at the time of observation, the Maintenance Director agreed the central supply room contained combustible storage and the corridor door to the room was propped open. The Maintenance Director removed the door wedge upon observation. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		resident and non-resident areas were evaluated. **Systematic Process** 1. The Maintenance Director, or designee, will conduct documented weekly inspections X 4 weeks of all doors to hazardous areas to ensure no door is held open, except by a magnetic lock tied to the fire alarm system. 2. Staff will be in-serviced on the importance of ensuring facility doors are only held open by the magnetic locks. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Documentation of the weekly inspections will be brought to the monthly QAPI meeting X 1 month for review, or until substantial compliance is met. Documentation of the staff in-services will be brought to the monthly QAPI meeting X 1 month for review. **Substantial Compliance Date** Substantial compliance can reasonably be expected to be met by 11/16/2023.	

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K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview; the facility failed to completely document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This	K 0353	**K353** **Immediate Corrective Action** The documentation form for the weekly dry sprinkler system gauge inspections was updated on 11/10/2023 to reflect the need to document the air pressure reading, and not simply that the pressure is being maintained. The forms for both dry sprinkler systems were updated. **Method to Assess Others** Documentation for both dry sprinkler systems were accounted for so no further evaluation is	11/16/2023

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	deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review with the Maintenance Director from 10:20 a.m. to 12:45 a.m. on 10/30/23, weekly dry sprinkler system gauge inspection documentation for the most recent 52 week period was incomplete. The weekly gauge inspections were documented with a check mark and not the pressure reading. Based on interview at the time of record review, the Maintenance Director stated the facility has two supervised dry sprinkler systems. The Maintenance Director stated he does check the gauges on a weekly basis and pressures are always the same, and would begin logging the gauge pressures moving forward. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		needed. **Systematic Process** The Maintenance Director, or designee, will continue to conduct documented weekly inspections of both dry sprinkler system gauges utilizing the new forms. Weekly inspections will then continue on an ongoing basis as part of the facility's life safety program. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Documentation of the weekly inspections will be brought to the monthly QAPI meeting X 1 month for review, or until substantial compliance is met. **Substantial Compliance Date** Substantial compliance can reasonably be expected to be met by 11/16/2023.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height			

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	are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:44 p.m. to 2:00 p.m. on 10/31/23, a five inch gap was noted at the meeting edges of the corridor doors in the corridor door set serving as the entrance to the Main Dining Room when each door was in the fully closed position. This gap was due to the door coordinator not functioning properly. Each door was equipped with a 20 minute fire resistance rating label affixed to the top of the door and each door in the smoke barrier door set was also equipped with latching hardware. Based on interview at the time of the observations, the Maintenance Director agreed that the door coordinator was not functioning properly, leaving a five inch gap at the meeting edge of the doors when closed.	K 0374	**K374** **Immediate Corrective Action** The door coordinator to the corridor doors at the entrance to the main dining room was replaced on 11/07/2023. **Method to Assess Others** The Maintenance Director, or designee, performed documented inspections on 10/30/23 of all other smoke barrier doors to ensure they are fully self-closing. All resident and non-resident areas were evaluated. **Systematic Process** The Maintenance Director, or designee, will conduct documented weekly inspections X 4 weeks of all smoke barrier doors to ensure they are fully self-closing. Monthly inspections will then continue on an ongoing basis as part of the facility's life safety program.	11/16/2023

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	This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Documentation of the weekly inspections will be brought to the monthly QAPI meeting X 1 month for review, or until substantial compliance is met. **Substantial Compliance Date** Substantial compliance can reasonably be expected to be met by 11/16/2023.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored			

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	energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 5 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2.4 requires spark-ignited generator sets in service to be exercised at least once a month with the available EPSS load for 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 10/30/23 from 10:20 a.m. to 12:45 p.m., the following monthly generator load documentation was noted: a) The 09/23/23 monthly load documenation	K 0918	**K918** **Immediate Corrective Action** The generator was run under the available load on 11/08/23 for 30 minutes. The 30-minute time frame was documented on the monthly testing form. **Method to Assess Others** The facility only has one emergency generator so no further evaluation was needed. **Systematic Process** The Maintenance Director, or designee, will now continue to conduct documented monthly load tests of the emergency generator for 30-minutes. Monthly testing will then continue on an ongoing basis as part of the facility's life	11/16/2023

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	shows start time was 12:00 p.m. and end time was 12:20 p.m. The run time was documented as 20 minutes. b) The 07/17/23 monthly load documenation shows start time was 10:33 a.m. and end time was 10:53 a.m. The run time was documented as 20 minutes. c) The 06/09/23 monthly load documenation shows start time was 2:50 p.m. and end time was 3:00 p.m. The run time was documented as 10 minutes. d) The 05/10/23 monthly load documentation shows start time was 12:00 p.m. and the end time was 12:06 p.m. The run time was documented as 6 minutes. e) The 04/17/23 monthly load documentation shows start time was 11.00 and the end time was 11.20 The run time was documented as 15 minutes. Based on an interview at the time of record review, the Maintenance Director confirmed the aforementioned monthly load testing of the facility's propane generator was not the required 30 minutes. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		safety program. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Documentation of the monthly testing will be brought to the monthly QAPI meeting X 1 month for review, or until substantial compliance is met. **Substantial Compliance Date** Substantial compliance can reasonably be expected to be met by 11/16/2023.	