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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/25/2022

NAME OF PROVIDER OR SUPPLIER **CASTLETON HEALTH CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **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
F 000	**INITIAL COMMENTS** Paper compliance to the Post Survey Revisit (PSR) completed on June 10, 2022, to the Recertification and State Licensure Survey completed on April 22, 2022. Review date: June 25, 2022 Facility number: 000149 Provider number: 155245 AIM number: 100266840 Castleton Health Care was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1, in regard to the Paper compliance to the PSR to the Recertification and State Licensure Survey Quality review completed on June 25, 2022	F 000		

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