STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155387	A. BUILDING **01** B. WING _____	R **02/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLETON HEALTHCARE CENTER	**2500 IOWA AVE** **CONNERSVILLE, IN 47331**

(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 000}	INITIAL COMMENTS A Post Survey Revisit (PSR to the Life Safety Code Recertification and State Licensure Survey conducted on 01/03/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/21/23 Facility Number: 000318 Provider Number: 155387 AIM Number: 100266550 At this PSR Life Safety Code survey, Caroleton Healthcare Center was found 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 (000) construction and fully sprinkled except the sprinkler riser room boiler room. The facility has a fire alarm system with smoke detection in the corridors, and spaces open to the corridors. The facility has a capacity of 50 and had a census of 50 at the time of this PSR visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had a detached laundry building, the detached Administration annex building, the detached twenty-four foot by twenty-foot garage, and the two detached twelve foot by six-foot metal storage sheds which were not sprinklered.	{K 000}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 000}	Continued From page 1 Quality Review completed on 02/22/23	{K 000}		