STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155271		ì	ILDING NG	ONSTRUCTION   ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 10/23/2024		
	PROVIDER OR SUPPLIER  S OF CASTLETON	SKILLED NURSING FACILITY,	THE	8400 C	CLEARVISTA PL NAPOLIS, IN 46256		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LL SC IDENTIFYANC DIFFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG E 0000	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG			DATE
Bldg	conducted by the In accordance with 42  Survey Date: 10/23  Facility Number: 0 Provider Number: 100  At this Emergency Waters of Castleton found in complianc Preparedness Requi Medicaid Participat CFR 483.73.  The facility has 114 the survey, the cens	00171 155271 267050 Preparedness survey, The Skilled Nursing Facility was e with Emergency rements for Medicare and ing Providers and Suppliers, 42	E 00	000	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute a admission or agreement by t facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are preparand/or executed in compliant with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance will Federal Medicare and Medicaid requirements.	n his r he fic red ce	
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/23 Facility Number: 0 Provider Number: AIM Number: 100	00171 155271	K 00	000	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute a admission or agreement by t facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are preparand/or executed in compliant with state and federal laws.	n his r he fic red	

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

(X6) DATE

Sherice Ricks Admin 11/08/2024

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.

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TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING (01) COMPLE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			01	COMPL	
		155271	B. WI	ING		10/23/	2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
\\\\\	OF CASTIFTON	SKILLED NILIDSING EACH ITY TH	8400 CLEARVISTA PL IE INDIANAPOLIS, IN 46256				
WATERS	OF CASILETON :	SKILLED NURSING FACILITY, TH	<u> </u>	INDIAN	IAPULIO, IN 40250		
(X4) ID	SUMMARY S	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
		ursing Facility was found not			This plan of correction		
	_	Requirements for Participation aid, 42 CFR Subpart 483.90(a),			constitutes a written allegation		
		re and the 2012 edition of the			of substantial compliance wi Federal Medicare and	tri	
	-	etion Association (NFPA) 101,			Medicaid requirements.		
Life Safety Code (LSC), Chapter 19, Existing				Medicald requirements.			
		ancies and 410 IAC 16.2.					
	Treatm care occupe	ancies and 110 Into 10.2.					
	This two story facili	ity was determined to be of					
	_	truction and fully sprinklered.					
	The facility has a fir	re alarm system with smoke					
	detection in the corr	ridors and in all areas open to					
	the corridor. The fa	cility has battery operated					
		all resident sleeping rooms.					
	_	apacity of 114 and had a					
	census of 45 at the t	time of this visit.					
	All areas where resi	idents have customary access					
		The facility has one detached					
	building providing s	storage services which was					
	not sprinklered.						
	Quality Review con	npleted on 10/25/24					
K 0300	NFPA 101						
SS=E Bldg. 01	Protection - Other						
	Based on observation	on and interview, the facility	K 0	300	K300- It is the intent of the fac	cility	11/08/2024
	_	tery operated smoke alarms			to ensure to replace battery	-	
	installed in 1 of ove	er 60 resident sleeping rooms in			operated smoke alarms install	ed	
		FPA 72. NFPA 72, 2010			in over 60 resident sleeping ro	oms	
	· ·	2.1.1.1 states inspection,			in accordance with NFPA 72 to	0	
	-	nance programs shall satisfy			meet set standards.		
		this Code and conform to the			1 CORRECTIVE ACTIONS		
		turer's published instructions.			TAKEN:		
		tes unless otherwise			a On 10.23.24 the		
		e manufacturer's published			Maintenance Supervisor/desig	jnee	
		and multiple-station smoke			replaced the battery-operated		
	-	aced when they fail to respond out shall not remain in service			smoke detector including the	,	
	to operability tests b	out shall not remain in service	Ī		battery in resident room 104 to	י	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155271	B. WI	ING		10/23/	/2024
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			LEARVISTA PL		
WATERS	OF CASTLETON	SKILLED NURSING FACILITY, TH	Е		IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	longer than 10 year	rs from the date of manufacture.			meet set standards. The		
	This deficient pract	tice could affect over 20			Administrator verified the work	∢ on	
	residents, staff and	visitors in the vicinity of			10.23.24.		
	resident sleeping R	oom 104.			2 ALL OTHERS WITH		
					POTENTIAL TO BE AFFECTI	ED:	
	Findings include:				a All residents and all staf	f	
					and visitors have the potential	to	
		ons with the Maintenance			be affected but none were.		
	_	our of the facility from 1:10 p.m.			3 MEASURES TO PREVE	NT	
	_	23/24, "01/12/12" was written on			REOCCURRENCE:		
		attery operated smoke			a On 10.30.24 the		
		n the suspended ceiling of			Administrator in serviced the		
		oom 104 The smoke detector			Maintenance Supervisor/desig	-	
		red from the ceiling to check			on the requirement to ensure	to	
	-	documentation affixed to the			replace the battery-operated		
		ased on interview at the time of			smoke alarms installed in resi	dent	
		ne Maintenance Director stated			sleeping rooms to meet set		
		ng used as a showroom for			standards.		
		t families. The showroom was			b Maintenance		
		n all other resident sleeping			Supervisor/designee will ensu		
		ere replaced last year due to			battery-operated smoke alarm		
		d the battery operated smoke			are maintained and tested per		
		Room 104 was more than ten			manufactures guidelines and	will	
	years old.				document the results on the		
					Battery-Operated Smoke Dete		
	_	e reviewed with the			Maintenance Log to be filed in		
		the Maintenance Director			Life Safety Binder as a part of		
	during the exit conf	terence.			facility's Preventive Maintenar	ıce	
	2.1.10(1)				Program. If any issues are		
	3.1-19(b)				discovered, they will be addre		
					and resolved immediately. The		
					Maintenance Supervisor/desig	_	
					will review with the Administra	itor	
					the inspection results.		
					c The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
	i e		i		I GOCHMANISTION IS IN NICCO		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL		
		155271	B. WI	NG		10/23	/2024	
NAME OF F	PROVIDER OR SUPPLIER	· {	•		ADDRESS, CITY, STATE, ZIP COD	-		
					LEARVISTA PL			
WATERS	OF CASILEION	SKILLED NURSING FACILITY, TH	1E	INDIANAPOLIS, IN 46256				
(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 APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	4 MONITORING		DATE	
					CORRECTIVE ACTION:			
					a The inspection results w	rill		
					be presented by the Maintena			
					Supervisor/designee to the			
					Administrator monthly and the	)		
					Administrator will present the			
					inspection results at the month	hly		
					Quality Assurance/Performan	ce		
					Improvement (QA/PI) meeting	J.		
					Inspection results and system			
					components will be reviewed	by		
					the QA/PI Committee with			
					subsequent plans of correctio			
					developed and implemented a	as		
					deemed necessary to ensure			
					compliance is maintained.			
					This plan of correction constitutes our credible			
						h		
					allegation of compliance wit all regulatory requirements.	n		
					Our date of compliance is			
					11/8/2024.			
K 0353	NFPA 101							
SS=F	Sprinkler System	- Maintenance and Testing						
Bldg. 01	Based on record res	view, observation and	VA	252	K353 – It is the intent of the		11/09/2024	
		ity failed to maintain automatic	K 0	333	facility to ensure to maintain		11/08/2024	
	· ·	n accordance with NFPA 25.			automatic sprinkler systems in	1		
		all sprinkler systems shall be			accordance with NFPA 25 to i			
	_	nd maintained in accordance			set standards.			
	-	ndard for the Inspection,			1.CORRECTIVE ACTIONS			
		enance of Water-Based Fire			TAKEN:			
	-	. NFPA 25, Section 4.1.4.1			1.On 10.3.24 the license	d		
	_	owner or designated			sprinkler contractor made repa			
		correct or repair deficiencies			to the dry and wet sprinkler			
	-	t are found during the			systems and corrected all			
	inspection, test and	maintenance required by this			deficiencies, and the			
	standard. Correction	ons and repairs shall be			documentation was put into th	ie		

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Event ID:

KCML21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
			ľ í			` ′	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155271	B. W	ING		10/23/	/2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
				1	_EARVISTA PL		
WATERS	OF CASTLETON	SKILLED NURSING FACILITY, TH	E	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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	performed by qualit	fied maintenance personnel or			Life Safety Binder to meet set		
	a qualified contractor	or. NFPA 25, Section 4.3.1			standards. The Administrator		
	requires records sha	all be made for all inspections,			verified the work on 10.23.24.		
	tests, and maintenar	nce of the system components			2.ALL OTHERS WITH		
	and shall be made a	vailable to the authority			POTENTIAL TO BE AFFECTE	ED:	
	having jurisdiction	upon request. This deficient			1.All residents and all sta	ıff	
	practice could affec	t all residents, staff and			and visitors have the potential	to	
	visitors.				be affected but none were.		
					3.MEASURES TO PREVEN	Т	
	Findings include:				REOCCURRENCE:		
	_				1.On 10.30.24 the		
	Based on review of	the sprinkler system			Administrator in serviced the		
		or's "Invoice #: i129173"			Maintenance Supervisor/desig	nee	
	documentation date				on the requirement to ensure		
	Administrator, the I	Director of Operations and the			dry and wet sprinkler system		
		or during record review from			inspections are conducted and	d if	
		o.m. on 10/23/24, deficiencies			any deficiencies are corrected		
	-	acility's wet sprinkler system.			documented to meet set		
		of the sprinkler system			standards.		
		or's "Work Performed"			2.Maintenance		
	_	d 07/22/24 indicated			Supervisor/designee will ensu	re	
	deficiencies were al	so noted for the facility's dry			the dry and wet sprinkler syste		
		The 01/26/24 wet sprinkler			inspections are conducted and		
		ocumentation stated "Further			any deficiencies are found the		
		nd quote to replace 1/4 in			are corrected and documented	-	
	_	is broken at the packing nut".			a part of the facility's Preventiv		
		orinkler system inspection			Maintenance Program and		
		ed "Further Work Required:			document those inspection res	sults	
		ce Tyco accelerator on 4" CSC			as appropriate. If any issues		
	• •	celerator did not reset after the			discovered, they will be addre		
	* * *	interview at the time of record			and resolved immediately. Th		
	_	nance Director stated the			Maintenance Supervisor/desig		
		the wet and dry sprinkler			will review with the Administra		
	•	repair documentation was not			the inspection results.	• =	
		at the time of the survey.			3.The Administrator will		
		ons with the Maintenance			monitor adherence to the		
		our of the facility from 1:10 p.m.			Preventative Maintenance		
	_	23/24, the facility has			schedule and validate the		
	-	dry sprinkler systems.			Preventative Maintenance		
	saper rised wet and	ary springer systems.			documentation is in place.		
1					. accamontation is in biaco.		i

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155271		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  10/23/2024		
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	8400 C	ADDRESS, CITY, STATE, ZIP COD LEARVISTA PL APOLIS, IN 46256	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LOCALISE DEPOTE THE STATE OF	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	
TAG	These findings were	he Maintenance Director	TAG	4.MONITORING CORRECTI ACTION:  1.The inspection results was be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed at the QA/PI Committee with subsequent plans of correction developed and implemented at deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/8/2024.	will nce nlly ce l. by n
K 0712 SS=F Bldg. 01	facility failed to do the second shift for practice affects all r Findings include: Based on review of documentation with Director of Operation	review and interview, the cument quarterly fire drills on 1 of 4 quarters. This deficient residents, staff and visitors.  "Fire Drill Report" at the Administrator, the cons and the Maintenance ord review from 9:20 a.m. to 8/24, documentation of a fire drill	K 0712	K712 –It is the intent of the facto ensure to document quarter fire drills on the second shift for 4 quarters and to conduct quarterly fire drills at unexpect times under varying conditions all three shifts for all four quart to meet set standards.  1 CORRECTIVE ACTIONS TAKEN:  a On 11.6.24 the Administrator in-serviced the	rly or all ted s on ters

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conducted within the most recent twelve month

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Maintenance Supervisor on

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155271	B. W	ING		10/23/2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	R			LEARVISTA PL		
WATERS	OF CASTLETON	SKILLED NURSING FACILITY, TH	ΙE		IAPOLIS, IN 46256		
(X4) ID	ı	STATEMENT OF DEFICIENCIE	1	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIO	ON
TAG	`	R LSC IDENTIFYING INFORMATION	1	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETIC	J1 1
		d shift in the fourth quarter			conducting fire drills once per	2.112	
		er, December) 2023 was not			shift, per quarter, at unexpecte	ed	
		. Based on interview at the			times, under varying condition		
		ew, the Maintenance Director			meet set standards. The		
		perates three shifts per day,			Administrator verified the work	con	
		documentation was not	1		11.6.24.		
	available for review	and agreed documentation of			2 ALL OTHERS WITH		
		d on the second shift in the			POTENTIAL TO BE AFFECTE	ED:	
	fourth quarter 2023	was not available for review.			a All residents and all staft	•	
					and visitors have the potential	to	
	These findings were				be affected but none were.		
		he Maintenance Director			3 MEASURES TO PREVE	NT	
	during the exit conf	Perence.	1		REOCCURRENCE:		
					1.On 10.30.24 the		
	3.1-19(b)				Administrator in serviced the		
	3.1-51(c)				Maintenance Supervisor/desig		
			1		on the requirement to ensure		
		review and interview, the			drills are completed once per		
	1	nduct quarterly fire drills at			per quarter, at unexpected tim	es,	
	_	nder varying conditions on the			under varying conditions and		
		quarters. This deficient			documented to meet set		
	1 ~	t all residents, staff and	1		standards.		
	visitors in the facilit	ıy.			b Maintenance	ro.	
	Findings include:				Supervisor/designee will ensu	l l	
	Findings include:				fire drills are completed once		
	Based on review of	"Fire Drill Report"	1		shift, per quarter, at unexpected times, under varying condition		
		the Administrator, the			a part of the facility's monthly	3 a3	
		ons and the Maintenance			Preventive Maintenance Progr	ram	
	1	ord review from 9:20 a.m. to			and document those inspection		
	_	3/24, first shift fire drills			results as appropriate. If any		
		ne most recent twelve month			issues are discovered, they w		
		07/22/24 and on 10/05/24, were			addressed and resolved		
	1 ~	ctively, 10:00 a.m., 10:15 a.m.			immediately. The Maintenance	e	
		sed on interview at the time of			Supervisor/designee will revie		
	record review, the Maintenance Director stated				with the Administrator the		
	the facility operates three shifts per day and		1		inspection results.		
		ntioned first shift fire drills			c The Administrator will		
		at unexpected times under			monitor adherence to the		
	varving conditions.	_			Preventative Maintenance		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED.
		155271	B. WI	NG		10/23/	2024
WATERS	T	SKILLED NURSING FACILITY, TH	IE	8400 C INDIAN	ADDRESS, CITY, STATE, ZIP COD LEARVISTA PL IAPOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY 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	These findings wer	e reviewed with the the Maintenance Director Ference.		TAG	schedule and validate the Preventative Maintenance documentation is in place.  4 MONITORING CORRECTIVE ACTION:  a The fire drill documentat will be presented by the Maintenance Supervisor/design to the Administrator monthly at the Administrator will present inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/8/2024.	gnee nd the hly ce by	DATE
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Insp	pection & Testing - Doors					
	interview; the facili operation was main fire doors in accord requires any device condition, arrangen other feature is requ provision of this Co	view, observation and ity failed to ensure the proper itained for 1 of 1 rolling steel ance with NFPA 80. LSC 4.5.8 , equipment, system, nent, level of protection, or any uired for compliance with the ode, such device, equipment, arrangement, level of	K 0'	761	K761 – It is the intent of the facility to ensure the proper operation is maintained for rol steel fire doors in accordance NFPA 80 to meet set standard 1 CORRECTIVE ACTIONS TAKEN:  a On 11.7.24 the facilities suppression company made	with Is.	11/08/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLI	ETED
		155271	B. WI	NG		10/23/2	2024
				CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD ELEARVISTA PL		
\A/A TED C	OF CACTLETON	CIVILLED NILIDOING EACH ITY TO	_				
WATERS	OF CASILETON	SKILLED NURSING FACILITY, TH		INDIAN	NAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	protection, or other	r feature shall thereafter be			repairs to the kitchen roll dow	n	
	maintained unless	the Code exempts such			door to meet set standards. T	īhe	
	maintenance. NFI	PA 80, 2010 Edition, the			Administrator verified the worl	k on	
	Standard for Fire I	Doors and Other Opening			11.7.24.		
	Protectives, Sectio	n 11.4.1.1 requires an			2 ALL OTHERS WITH		
	automatic-closing	device shall be installed on			POTENTIAL TO BE AFFECTI	ED:	
	every rolling steel	door. Section 11.4.1.2 states			a All residents and all staf	f	
	rolling steel doors	shall close automatically upon			and visitors have the potential	to	
	activation or releas	se of a fusible link or detector.			be affected but none were.		
	Section 11.4.2.2.1	states after the automatic			3 MEASURES TO PREVE	:NT	
		l, the door shall remain in the			REOCCURRENCE:		
	closed position unt	til the automatic-closing device			a On 10.30.24 the		
	has been reset. Th	is deficient practice could			Administrator inserviced the		
	affect over 20 resid	dents, staff and visitors in the			maintenance Supervisor to er	isure	
	main Dining Roon	n on the first floor.			proper operation is maintained	d for	
					rolling fire doors to meet set		
	Findings include:				standards.		
					b Maintenance		
		f the rolling fire door inspection			Supervisor/designee will ensu	re	
		Alarm System Inspection"			proper operation is maintained	d for	
		ed 03/15/24 with the			rolling fire doors as a part of the	ne	
		Director of Operations and the			facility's annual Preventive		
		etor during record review from			Maintenance Program and		
		p.m. on 10/23/24, "the roll door			document those inspection re-		
		hanically after test" and was			as appropriate. If any issues		
		the result of 03/15/24			discovered, they will be addre		
	-	ing. Review of the rolling fire			and resolved immediately. The	ne	
	_	ntractor's "Work Performed"			Maintenance Supervisor/design		
		ed 09/26/24 indicated "was not			will review with the Administra	ıtor	
		or due to it being broke. They			the inspection results.		
	_	r new door to come in". Based			c The Administrator will		
		time of record review, the			monitor adherence to the		
		ions provided a letter from a			Preventative Maintenance		
	-	ontractor stating "The			schedule and validate the		
	-	for the kitchen roll down door			Preventative Maintenance		
		We attempted to install it on			documentation is in place.		
		e manufacturer sent us the			4 MONITORING		
		ave not got a ETA on the			CORRECTIVE ACTION:		
	_	ll be installed as soon as			a The inspection results w		
	possible once it an	rives". Based on interview at			be presented by the Maintena	ince	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	·	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155271	B. WI	NG		10/23/2024	
	PROVIDER OR SUPPLIER	SKILLED NURSING FACILITY, TH	IE_	8400 CI	ADDRESS, CITY, STATE, ZIP COD LEARVISTA PL APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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	
	the time of record re Operations stated the repairs to the rolling survey. Based on of Maintenance Direct from 1:10 p.m. to 2 rolling fire door bet Dining Room on the position and was eques resistance label affire Room was open to the	eview, the Director of e facility is still awaiting g fire door at the time of the bservations with the or during a tour of the facility 40 p.m. on 10/23/24, the metal ween the kitchen and main e first floor was in the closed uipped with a 90-minute fire ked to the door. The Dining the corridor.			Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/8/2024.	nlly ce by	
K 0918 SS=F Bldg. 01	1. Based on record of facility failed to exemeet the requirement the Standard for Em Systems, Chapter 8. generator sets in ser once monthly, for a one of the following (1) Loading that magas temperatures as manufacturer (2) Under operating not less than 30 per Power Supply) nam Section 8.4.2.3 states	intains the minimum exhaust recommended by the temperature conditions and at cent of the EPS (Emergency	K 09	918	K918 – It is the intent of the facility to ensure to exercise the generator annually to meet the requirements of NFPA 110, 20 edition, the standard for emergency and standby power systems, chapter 8.4.2 and to ensure to document 36-month period emergency generator testing for emergency generator in accordance with NFPA 99 at NFPA 110 to meet set standard CORRECTIVE ACTIONS TAKEN:  a On 11.8.24 the licensed contractor conducted the 4-ho	ors and rds.	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLI	ETED
		155271	B. WI	ING		10/23/2	2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			LEARVISTA PL		
\\\\\\TED\$	COE CASTI ETON	SKILLED NITBSING EVOLUTY TH	<b>=</b>		APOLIS, IN 46256		
VVATERS	OF CASILETON	SKILLED NURSING FACILITY, TH		INDIAN	AFULIS, IN 40230		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ised monthly with the available			load bank test on the generate	or	
		Power Supply System) load and			and document the results in th	ne	
		nnually with supplemental			facilities Life Safety Binder to		
		Cest) at not less than 50 percent			meet set standards. The		
	-	te kW rating for 30 continuous			Administrator verified the work	c on	
		less than 75 percent of the EPS			11.8.24.		
	-	g for 1 continuous hour for a			2 ALL OTHERS WITH		
		f not less than 1.5 continuous			POTENTIAL TO BE AFFECTE		
		nt practice could affect all			a All residents and all staff		
	residents, staff and	visitors.			and visitors have the potential	to	
					be affected but none were.		
	Findings include:				3 MEASURES TO PREVE	NT	
					REOCCURRENCE:		
		Emergency Generator-Monthly			a On 10.30.24 The		
	-	tation for the most recent			Administrator inserviced the		
	-	d with the Administrator, the			Maintenance Supervisor/desig		
	_	ons and the Maintenance			on the requirement to ensure		
	_	ord review from 9:20 a.m. to			generator is ran at 30% or hig	her	
	_	3/24, the actual load percentage			on the monthly load test and		
		mmins diesel fuel fired			documented in the life safety		
		or during monthly load testing			binder to meet set standards.		
		eed 30% or higher for any of			b The Maintenance		
		load tests. Based on interview			Supervisor/designee will ensu		
		d review, the Maintenance			the generator is ran at 30% or		
		ual supplemental load bank			higher on the monthly load tes		
		on for the most recent twelve			and documented in the life saf	-	
	month period was n	ot available for review.			binder as a part of the facility's		
	TEI (* 1'				monthly Preventive Maintenar		
	_	e reviewed with the			Program and document those		
		he Maintenance Director			inspection results as appropria		
	during the exit conf	erence.			If any issues are discovered, t	-	
	2 1 10/b)				will be addressed and resolve		
	3.1-19(b)				immediately. The Maintenand		
	2. Based on record review, observation, and				Supervisor/designee will revie with the Administrator the	vv	
	2. Based on record review, observation, and interview; the facility failed to document 36-month				inspection results.		
					l ' <u>-</u>		
	period emergency generator testing for 1 of 1						
	emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities				monitor adherence to the		
					Preventative Maintenance		
	Code, 2012 Edition	, Section 6.4.1.1.6.1 states Type	I		schedule and validate the	l	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155271	B. W	ING		10/23/	/2024
				_	_		
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					LEARVISTA PL		
WATERS	S OF CASTLETON	SKILLED NURSING FACILITY, TH	ΙE	INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDERIC DI ANI OF CORRECTIONI		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE	DATE
		tial electrical system power			Preventative Maintenance		
		all be classified as Type 10,			documentation is in place.		
		enerator sets per NFPA 110.			4 MONITORING		
	_	ndard for Emergency and			CORRECTIVE ACTION:		
		estems, 2010 Edition, Section			a The inspection results w	ill	
		EPSS shall be tested at least			be presented by the Maintena		
		36 months. Section 8.4.9.1			Supervisor/designee to the		
		S shall be tested continuously			Administrator monthly and the	1	
		its assigned class (See Section			Administrator will present the	•	
		.2 states where the assigned			inspection results at the month	alv	
	· /	1.4 hours, it shall be permitted			Quality Assurance/Performan	-	
	_	t after 4 continuous hours.			Improvement (QA/PI) meeting		
		es the minimum load for this			Inspection results and system		
		ed in 8.4.9.5.1, 8.4.9.5.2, or			components will be reviewed		
	_	8.4.9.5.3 states for spark-ignited			the QA/PI Committee with	IJ	
		l be the available EPSS load.				<b>n</b>	
	_	tice could affect all residents,			subsequent plans of correction		
	staff, and visitors.	fice could affect all fesidents,			developed and implemented a deemed necessary to ensure	15	
	starr, and visitors.						
	Findings include:				compliance is maintained.		
	rindings include.				This plan of correction constitutes our credible		
	Rosed on record re	view with the Administrator,			allegation of compliance with	h	
		erations and the Maintenance			all regulatory requirements.	11	
	•	ord review from 9:20 a.m. to			, , ,		
	_	3/24, thirty-six-month period			Our date of compliance is		
	_	or testing documentation for			11/8/2024.		
		urs for the Cummins diesel					
		nerator was not available for					
		"4 hour Load Bank Load Test					
	_	onducted by facility staff and					
		icated the load percent for the					
		our test never exceeded 29%					
		erview at the time of record					
		r of Operations and the					
		tor stated additional					
		upplemental load testing for					
		ne most recent three-year					
		ilable for review. Based on					
		he Maintenance Director					
	during a tour of the	facility from 1:10 p.m. to 2:40					

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	
		155271	B. WING			10/23/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					LEARVISTA PL		
WATERS	OF CASTLETON	SKILLED NURSING FACILITY, TH	E		IAPOLIS, 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 ACTIO CROSS-REFERENCED TO THE		OULD BE COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG		DEFICIENCY)		DATE
	•	ne facility has one Cummins					
	_	ncy generator located outside					
	the building on the north side of the property.						
	The manufacturer's nameplate rating for the generator indicated the generator was rated at 80						
	kW.						
	These findings were	a marriarry and resistantle a					
	_						
	Administrator and the Maintenance Director during the exit conference.						
	during the exit com	crence.					
	3.1-19(b)						
K 0920	NFPA 101						
SS=E	Electrical Equipment - Power Cords and						
Bldg. 01	Extens						
J		on and interview, the facility	K 09	920	K920 – It is the intent of the		11/08/2024
		f 1 extension cords including	110.	, 20	facility to ensure extension co	rds	11/00/2021
		ot used as a substitute for			including power strips are not		
		19.5.1 requires utilities to			used as a substitute for fixed		
		n 9.1. LSC 9.1.2 requires			wiring to meet set standards.		
		d equipment to comply with			1.CORRECTIVE ACTIONS		
		Electrical Code, 2011 Edition.			TAKEN:		
	NFPA 70, Article 4	00.8 requires that, unless			1.On 10.23.24 the		
		ed, flexible cords and cables			Maintenance Supervisor/desig	jnee	
		a substitute for fixed wiring of			removed the power strip from		
	a structure. LSC Se	ection 4.5.7 states any building			med room on the first floor by		
	service equipment of	or safeguard provided for life			nurse's station to meet set		
	,	gned, installed and approved			standards. The Administrator		
	in accordance with	all applicable NFPA standards.			verified the removal on 10.23.	24.	
	This deficient pract	ice could affect over 10			2.ALL OTHERS WITH		
		visitors in the vicinity of the			POTENTIAL TO BE AFFECTE	ED:	
	Med Room on the 1	st floor by the nurse's station.			1.All residents and all sta	ff	
					and visitors have the potential	to	
	Findings include:				be affected but none were. O	)n	
					10.23.24 the Maintenance		
		ons with the Maintenance			Supervisor/designee inspected		
	Director during a tour of the facility from 1:10 p.m.				rooms throughout the facility for	or	
	-	23/24, a refrigerator and a Med			power strips and extension co	rds	
	Bank device were plugged into a power strip		1		and found no other negative		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED		
	155271		B. W	ING		10/23/2024	
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			LEARVISTA PL		
WATERS	OF CASTLETON	SKILLED NURSING FACILITY, TH	IE		IAPOLIS, 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	ON
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	placed on the floor in the Med Room on the first				findings.		
		station. Based on interview at			3.MEASURES TO PREVEN	Г	
	the time of the observations, the Maintenance				REOCCURRENCE:		
	Director agreed a power strip was being used as a				1.On 10.23.24 the		
		wiring at the aforementioned			Administrator inserviced the		
		ged the refrigerator from the			Maintenance	-1-66	
	power strip.				Supervisor/designee/all other		
	These findings were reviewed with the				that power strips and extension	"	
	_				cords are not to be used as a	oot	
	Administrator and the Maintenance Director during the exit conference.				substitute for fixed wiring to m set standards.	CCI	
	during the exit com	crence.			2.Maintenance		
	3.1-19(b)				Supervisor/designee will inspe	oct .	
	3.1-17(0)				all rooms throughout the facilit		
					monthly to ensure they do not	•	
					have power strips or extension		
					cords in use as a part of the	'	
					facility's Preventive Maintenar	nce	
					Program and document those		
					inspection results as appropria		
					If any issues are discovered, t		
					will be addressed and resolve	-	
					immediately. The Maintenand		
					Supervisor/designee will revie		
					with the Administrator the		
					inspection results.		
			1		3.The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4.MONITORING CORRECT	VE	
			1		ACTION:		
					1.The inspection results		
					be presented by the Maintena	nce	
			1		Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	nly	

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

PRINTED: 11/14/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155271	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/23/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF CASTLETON SKILLED NURSING FACILITY, TH				STREET ADDRESS, CITY, STATE, ZIP COD  8400 CLEARVISTA PL  INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE CH DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
					Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/8/2024.	oy n as	

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