STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155387	A. BUILDING -- B. WING	04/17/2025

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

(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: 04/17/25 Facility Number: 000318 Provider Number: 155387 AIM Number: 100266550 At this Emergency Preparedness survey, Caroleton Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 50 certified beds. At the time of the survey, the census was 46. Quality Review completed on 04/22/25	E 0000	**Survey Date: 04/17/2024** **EOOO** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the findings of noncompliance cited during the on-site Life-Safety survey/quality review/licensure review conducted 04/19/2024. Please accept this plan of correction as the provider's credible findings/verification of compliance. The facility would like to respectfully request a desk review. Respectfully Submitted, Tonya James, LHFA Executive Director Caroleton Healthcare	
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).	K 0000	**Survey Date: 04/17/2024** **EOOO** Preparation or execution of this plan of correction does not constitute admission or agreement	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tonya James., LHFA	Executive Director	05/02/2025

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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	Survey Date: 04/17/25 Facility Number: 000318 Provider Number: 155387 AIM Number: 100266550 At this Life Safety Code survey, Caroleton Healthcare 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(000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 50 and had a census of 46 at the time of this 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. Quality Review completed on 04/22/25		of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the findings of noncompliance cited during the on-site Life-Safety survey/quality review/licensure review conducted 04/19/2024. Please accept this plan of correction as the provider's credible findings/verification of compliance. The facility would like to respectfully request a desk review. Respectfully Submitted, Tonya James, LHFA Executive Director Caroleton Healthcare	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of 4 means of egress was	K 0211	**0211: Means of Egress • General CFR(s): NFPA**	04/17/2025

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	continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during an initial walk through of the facility at 9:40 a.m. on 04/17/25, a portable wooden Therapy Room two step stair device was stored in the east corridor outside the Therapy Room. Based on observations with the Maintenance Director at 2:06 p.m. on 04/17/25, the portable wooden Therapy Room two step stair device was still stored in the east corridor outside the Therapy Room and it projected 36 inches into the eight foot wide corridor. Based on interview at 2:06 p.m. on 04/17/25 and during the exit conference at 2:20 p.m. on 04/17/25, the Maintenance Director stated the Therapy Room is too small to utilize the stair device in the room, it is only moved to the corridor during the day when it is used for Therapy purposes but agreed the aforementioned means of egress would not be continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency when stored in the corridor. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**101** **SS = E** 1. No residents, staff or visitors have been affected/harmed by the alleged deficient practice Therapy rehabilitative stairs will be stored in other location when not in use & will be used in the therapy working room, when in use. The aisles, hallways, passageways, corridor was immediately cleared of any/all obstructions, to ensure full use in case of emergency. All other areas observed for egress obstruction and any concerns resolved. 2.. All residents, visitors and staff have the potential to be affected. All other areas observed for egress obstruction and any concerns resolved. 3. Maintenance Director or designee will provide education related to "Means of Egress" and that all corridors, hallways, aisles., etc., remain cleared and are free of obstruction. 4. The Maintenance Director and/or designee will complete weekly audits of "Means of Egress" (Ix) times per week for four (4) weeks, then (Ix) time every other week for four (4) weeks, and then Ix per month thereafter. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to	

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			adjusting the frequency of audits. Plan to be updated as indicated after review of Quality Assurance/Performance Improvement Committee.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director at 10:40 a.m. on 04/17/25, sprinkler system internal pipe inspection documentation within the most recent five year period was not available for review. Based on observations with the Maintenance Director at 10:45 a.m. on 04/17/25, the sprinkler system inspection contractor had affixed a sticker to the sprinkler system in the sprinkler riser room indicating the most recent internal pipe inspection was conducted on 01/13/20. Based on interview at 2:20 p.m. on	K 0353	**K0353: Sprinkler System - Maintenance and Testing** **CFR(s): NFPA 101** **SS = E** **Corrective action for the residents found to have been affected by the deficient practice:** 1 No resident(s) or staff members, visitors were found to have been affected/are harmed by the alleged deficient practice. 2 All residents, visitors and staff have the potential to be affected. Maintenance Director and/or designee ensured completion of all required inspection(s), examination(s) and/or necessary flushing and repairs, to ensure the automatic sprinkler piping system, internal piping/branch line systems were thoroughly inspected, examined and were found to have NO foreign material of organic, inorganic or any other obstructions present. 3 Administrator and/or other designee completed education/in-service with Maintenance Director and/or all required facility staff regarding	04/17/2025

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	04/17/25, the Maintenance Director provided a letter from the sprinkler system inspection contractor dated 04/17/25 stating the five year internal pipe inspection is scheduled for 04/22/25. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		"SPRINKLER SYSTEM-MAINTENANCE AND TESTING", specifically regarding all routine & required inspections of automatic sprinkler piping, internal piping/ branch-line piping systems will be completed timely as required to ensure compliance with NFPA 101 4 Administrator/Maintenance Director/Designee completed facility audit to ensure there are no outstanding required inspections, examinations or flushing requirements for any automatic sprinkler piping system, internal piping/branch-line piping systems or other internal piping mechanisms. Administrator/Maintenance Director/Designee will conduct monthly audit to ensure there are no outdated, expired, over-due or outstanding maintenance-testing of any automatic sprinkler piping system, internal piping/branch line systems. The Administrator/Maintenance Director/Designee will present the results of these audits to the monthly QAPI/QA committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI/QA committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure one of four corridors was not used as a treatment room. LSC Section 19.3.6.1 (1) (a) says that a space may be open to the corridor as long as the space is not used as a treatment room. This deficient practice could affect over 10 residents, staff and visitors utilizing the east corridor. Findings include: Based on observations with the Maintenance Director during an initial walk through of the facility at 9:40 a.m. on 04/17/25, a portable wooden Therapy Room two step stair device was stored in the east corridor outside the Therapy Room. Based on observations with the Maintenance Director at 2:06 p.m. on 04/17/25, the portable wooden Therapy Room two step stair device was still stored in the east corridor outside the Therapy Room. Based on interview at 2:06 p.m. on 04/17/25 and during the exit conference at 2:20 p.m. on 04/17/25, the Maintenance Director stated the Therapy Room is too small to utilize the stair device in the room, it is only moved to the corridor during the day when it is used for Therapy purposes but agreed the aforementioned means of egress was being used as a treatment area and was not separated from the corridor. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)	K 0361	**0361: Corridors. Areas open to Corridor-CFR(s): NFPA 101** **SS = E** 1. No residents, staff or visitors have been affected/harmed by the alleged deficient practice. Therapy rehabilitative stairs will be stored in other location when not in use & will be used in the therapy working room, when in use. The aisles, hallways, passageways, corridor was immediately cleared of any/all obstructions, to ensure full use in case of emergency. 2 All residents, visitors and staff have the potential to be affected. All other areas observed for egress obstruction and any concerns resolved. 3 Maintenance Director and/or designee will provide education related to "Means of Egress" and that all corridors, hallways, aisles., etc., remain cleared and are free of obstruction. 4 The Maintenance Director and/or designee will complete weekly audits of "Means of Egress" (1x) times per week for four (4) weeks, then (1x) time every other week for four (4) weeks, and then 1x per month thereafter. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The	04/17/2025

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			facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated after review of Quality Assurance/Performance Improvement Committee.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 3 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the resident sleeping Room SO1. Findings include: Based on observations with the Maintenance Director at 2:17 p.m. on 04/17/25, the annular space surrounding a four inch in diameter horizontal sprinkler pipe which penetrated the attic smoke barrier wall above the corridor door set by resident sleeping Room SO1 was not firestopped. The corridor door set by resident sleeping Room SO1 was equipped with 90-minute fire resistance rating labels affixed to the hinge side of the door. Based on interview at 2:17 p.m. on 04/17/25, the Maintenance Director agreed the aforementioned opening in the attic smoke barrier wall above the corridor door set by resident sleeping Room SO1 did not maintain the fire resistance rating of the smoke barrier wall.	K 0372	**K0372 Subdivision of Building Spaces. Smoke Barrier Construction-CFR(s): NE-PA 101 SS = E** 1. No residents, staff or visitors have been affected/harmed by the alleged deficient practice. The smoke barrier wall located in the attic, was immediately repaired to ensure fire resistance rating is maintained. 2. All residents have the potential to be affected. An audit was completed of smoker barrier walls within the facility with no concerns. 3. The Executive Director educated the Maintenance Director on "Subdivision of Building Spaces-Smoke Barrier Construction-- CFR(s): NFPA 101. 4. The Maintenance Director and/or designee will complete weekly audits of "Subdivision of Building Spaces-Smoke Barrier Construction-- CFR(s): NFPA 101" (Ix) times per week for four (4) weeks, then (Ix) time every other week for four (4) weeks, and then	04/18/2025

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	These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		lx per month thereafter. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated after review of Quality Assurance/Performance Improvement Committee.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review, observation and interview; the facility failed to ensure documentation of the transfer time to the alternate power source was within 10 seconds for 12 months of the most recent 12 month period. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Generator: Emergency Generators Monthly Generator Exercise and Inspection (under load)" documentation with the Maintenance Director at 10:50 a.m. on 04/17/25, monthly load testing documentation for the most recent twelve month period indicated the transfer time to the alternate power source exceeded 10 seconds. The "Transfer time to Emergency Power" was listed as "15 seconds" on monthly emergency generator load testing conducted on 04/30/24, 05/31/24, 06/28/24, 07/31/24, 08/30/24, 09/30/24, 10/31/24, 11/27/24, 12/26/24, 01/31/25, 02/28/25 and on	K 0918	**K0918: Electrical Systems-Essential Electrical Systems - General CFR(s): NFPA 101** **SS = F** 1 . No residents, staff members or visitors were affected by the alleged deficient practice. The procedures/monitoring of "Emergency Generator Monthly Generator Exercise & Inspection (under load) and "Transfer Time to Emergency Power" were immediately reviewed, addressed & appropriate measures/interventions taken to ensure the "Transfer Time to Emergency Power) occurs within 10 seconds as required. 2. All residents have the potential to be affected by the issues cited in the statement of deficiencies. The facility has contracted with	05/01/2025

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	03/31/25. In addition, review of the emergency generator inspection contractor's inspection documentation dated 07/16/24 and 12/19/24 indicated "NA" in response to "Check the unit for capability to be on line within ten seconds". Review of the emergency generator inspection contractor's "Load Bank Test Report" documentation dated 07/15/24 did not state the transfer time in seconds to the alternate power source. Based on interview at 10:50 a.m. on 04/17/25, the Maintenance Director stated he counted off the transfer time in seconds in his head during monthly load testing and agreed it could not be ensured the transfer time to the alternate power source was within 10 seconds for any generator inspection and testing documentation within the most recent 12 month period. Based on observations with the Maintenance Director at 1:25 p.m. on 04/17/25, the facility has one propane fired emergency generator located outside the building on the east side of the property. Manufacturer's nameplate documentation affixed to the generator indicated it was rate at 25 kW. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		SafeCare for generator services & Safe Care will also assess & determine if the age of the generator equipment, is such that replacement is recommended and/or if programming of the current generator can be modified to accommodate requirements. An appointment is scheduled with Safe Care to assess/evaluate the generator & determine whether it should be repaired/modified or replaced. 3.Maintenance Director and/or designee will be provided education related to "Electrical Systems-Essential Electrical Systems and Generator Monthly Exercise & Inspection. 4. The and/or designee will complete weekly audits of '"Electrical Systems-Essential Electrical Systems and Generator Monthly Exercise & Inspection" (1 x) times per week for four (4) weeks, then (1 x) time every other week for four (4) weeks, and then Ix per month thereafter. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated after review of Quality Assurance/Performance	

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			Improvement Committee.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 extension cords were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room SO2. Findings include:	K 0920	**K0920: Electrical Equipment: Power Cords and Extension- General CFR(s): NFPA 101** **SS = E** 1 . No residents, staff members or visitors have been found to be affected by alleged deficient practice. 2.All residents have the potential to be affected. A facility audit was completed to identify power strips with no other concerns identified. 3. Maintenance Director, Resident Ambassador(s) and/or designee, will be provided education related to the use of "Electrical Equipment- Power Cords and Extensions". 4. The Maintenance Director and/or designee will complete weekly audits of '"Electrical Equipment- Power Cords and Extensions" (1 x) times per week for four (4) weeks, then (1 x) time every other week for four (4) weeks, and then Ix per month thereafter. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee, The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated	04/17/2025

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	Based on observations with the Maintenance Director at 1:48 p.m. on 04/17/25, a life alert transmission device, the resident bed and two cell phone charging cables were plugged into a power strip on the floor near the resident bed by the window in resident sleeping Room SO2. The power strip was listed as UL 1363A. Based on interview at 1:48 p.m. on 04/17/25, the Maintenance Director agreed a power strip was being used in the patient care vicinity for PCREE and non-PCREE and was being used as a substitute for fixed wiring in resident sleeping Room SO2. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		after review of Quality Assurance/Performance Improvement Committee.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for all Patient Care Related Electrical Equipment (PCREE). NFPA 99, Health Care Facilities Code, 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions,	K 0921	**K0921: Electrical Equipment: Testing and Maintenance Requirements, General CFR(s): NFPA 101** **SS = E** 1 . No residents, staff members or visitors have been found to be affected by alleged deficient practice. 2. All resident have the potential to be affected. Facility wide PCREE testing was completed and documentation completed. **3.** **/p>**	04/30/2025

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	04/17/2025

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

(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
	and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents in the facility. Findings include: Based on record review with the Maintenance Director at 12:19 p.m. on 04/17/25, PCREE testing documentation was not available for review. Based on interview at 12:19 p.m. on 04/17/25, the Maintenance Director agreed PCREE testing documentation was not available for review. Based on observations with the Maintenance Director at 1:48 p.m. on 04/17/25, the resident bed in Room SO2 nearest the window was an electric bed. An oxygen concentrator was also near the bed in the room. Based on observations with the Maintenance Director at 1:50 p.m. on 04/17/25, an oxygen concentrator was also in use in resident sleeping Room SO4. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			