STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING -- B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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 Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/24/23 Facility Number: 001144 Provider Number: 155668 AIM Number: 200256980 At this Emergency Preparedness survey, Charlestown Place at New Albany was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR Subpart 483.73. The facility has 172 total beds with 158 certified beds. At the time of the survey, the census was 118. The Assisted Living area was surveyed due to the lack of a 2 hour fire-rated separation between the skilled care areas and the Assisted Living areas. Quality Review completed on 08/30/23	E 0000	Allegation of Compliance Please accept the following plan of correction for the Life Safety Code Recertification and State Licensure Survey completed on August 24, 2023. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
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	Allegation of Compliance Please accept the following plan of correction for the Life Safety Code	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jesse Ray		09/08/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	Survey Date: 08/24/23 Facility Number: 001144 Provider Number: 155668 AIM Number: 200256980 At this Life Safety Code survey, Charlestown Place at New Albany 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 sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, plus hard wired smoke detectors with battery back up in all resident sleeping rooms and several staff offices connected to a panel at the Nurses' Station (not the main fire alarm control panel). The facility has a total capacity of 172 with 158 certified beds and had a census of 118 at the time of this visit. The Assisted Living area was surveyed due to the lack of a 2 hour fire-rated separation between the skilled care areas and the Assisted Living area. The 200 Hall was not surveyed due to Covid-19 concerns. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 08/30/23		Recertification and State Licensure Survey completed on August 24, 2023. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
K 0100 SS=E	NFPA 101 General Requirements - Other			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
Bldg. 01	General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure corridor doors to 6 of over 50 rooms would close and latch into the door frame per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations with the Executive Director, the Housekeeping Manager, and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, the following was noted: a. the corridor door to the service hall was equipped with a self-closing device but the door would not self-close and latch into the door frame when tested to close multiple times. b. the single corridor door to the North Dining Room was equipped with latching hardware but the door did not latch into the door frame when tested to close multiple times. c. one of two doors in the corridor door set to the North Dining Room was equipped with latching hardware but the door did not latch into the door frame when tested to close multiple times. The other door in the corridor door set was equipped with latching hardware but the latching mechanism on the door frame was removed. d. one of two doors in the corridor door set to the	K 0100	1. 1. No residents were found to be affected by the alleged deficient practice. The doors identified during the survey were corrected and close and latch into the door frame. 2. 2. All residents have the potential to be affected by the alleged deficient practice. 3. 3. The maintenance staff has been educated on the LSC requirements and NFPA standards. 4. 4. Facility doors will be audited monthly to validate that each door properly closes and latches into the door frame. The quality assurance committee will review the performance improvement tool for compliance and make further recommendations as needed.	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	South Dining Room was equipped with latching hardware but the door did not latch into the door frame when tested to close multiple times. e. one of two doors in the corridor door set to the Assisted Living Dining Room was equipped with latching hardware but the door did not latch into the door frame when tested to close multiple times. f. one of two doors in the corridor door set to the Activities Room was equipped with latching hardware but the door did not latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Assistant agreed the aforementioned door locations did not latch into the door frame when tested to close multiple times. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 11 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice	K 0211	1. 1. No residents were found to be affected by the alleged deficient practice. The items identified were removed immediately during the survey and	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Executive Director, the Housekeeping Manager and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, a plastic three drawer chest of drawers for isolation supplies was stored in the corridor outside Room 118. The chest of drawers projected 12.5 inches into the six foot wide corridor. In addition, a couch was stored in the corridor at the entrance to the "Center" by the 300 Hall exit door. The couch projected 32 inches into the 8 foot wide corridor. All measurements were made using the Maintenance Assistant's measuring tape. Based on interview at the time of the observations, the Housekeeping Manager and the Maintenance Assistant agreed the aforementioned means of egress were not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)		continue to be unobstructed. 2. 2. All residents have the potential to be affected by the alleged deficient practice. 3. 3. The maintenance staff has been educated on the LSC requirements and NFPA standards regarding maintaining means of egress of obstructions and impediments for emergency use. 4. 4. Means of egress will be audited weekly to validate that areas are continuously maintained free of obstructions or impediments for emergencies. The quality assurance committee will review the performance improvement tool for compliance and make further recommendations as needed.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over all residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Executive Director, the Housekeeping Manager and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, the front lobby exit door and the exit door to the "Center" near the adult day care area were each marked as a facility exit with an exit sign. Each exit door could be opened by entering a four digit code into a keypad at the exit door but the code	K 0222	1. 1. Door codes were posted and securely affixed to each exit door identified during the survey. 2. 2. All residents have the potential to be affected by the alleged deficient practice. 3. 3. The maintenance staff has been educated on the LSC requirements and NFPA standards regarding maintaining means of egress of obstructions and impediments for emergency use. 4. 4. Means of egress will be audited weekly to validate that areas are continuously maintained free of obstructions or impediments for emergencies. The quality assurance committee will review the performance improvement tool for compliance and make further recommendations as needed.	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	was not posted at the exit doors. Based on interview at the time of the observations, the Executive Director stated residents with a clinical diagnosis requiring specialized security measures reside in the 500 Hall and agreed the code was not posted at the two exit doors. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)			
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 2 of 11 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square	K 0232	1. 1. No residents were found to be affected by the alleged deficient practice. The items identified were removed immediately during the survey and continue to be unobstructed. 2. 2. All residents have the potential to be affected by the alleged deficient practice. 3. 3. The maintenance staff has been educated on the LSC requirements and NFPA standards regarding maintaining means of egress of obstructions and impediments for emergency use. 4. 4. Means of egress will be	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Executive Director, the Housekeeping Manager and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, a plastic three drawer chest of drawers for isolation supplies was stored in the corridor outside Room 118. The chest of drawers projected 12.5 inches into the six foot wide corridor. In addition, a couch was stored in the corridor at the entrance to the "Center" by the 300 Hall exit door. The couch projected 32 inches into the 8 foot wide corridor. The couch was not affixed to the floor or to the wall. All measurements were made using the Maintenance Assistant's measuring tape. Based on interview at the time of the observations, the Housekeeping Manager and the Maintenance Assistant agreed the aforementioned chest of		audited weekly to validate that areas are continuously maintained free of obstructions or impediments for emergencies. The quality assurance committee will review the performance improvement tool for compliance and make further recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	drawers and the couch were stored in the path of egress. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on record review, observation and interview; the facility failed to document monthly testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents,	K 0291	1.1. No residents were found to have been affected by the alleged deficient practice. The emergency lighting device at the 900 hall exit was replaced and operating. All of the facilities battery backup lights were tested for 30 seconds and documented accordingly. 2.All residents have the potential to be affected by the alleged deficient practice. 3.The maintenance staff has been educated on the LSC requirements and NFPA standards to perform and document monthly testing. 4.The quality assurance committee will review the performance improvement tool for compliance and make further recommendations as needed.	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Lighting: Check exit lighting and exit signs 30 second test" documentation with the Executive Director during record review from 10:15 a.m. to 12:30 p.m. on 08/24/23, monthly battery operated light testing documentation after May 2023 was not available for review. Based on interview at the time of record review, the Executive Director stated additional monthly battery operated light testing documentation was not available for review. Based on observations with the Executive Director, the Housekeeping Manager and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, a total of four battery operated lighting systems were noted in the facility. Each battery operated lighting system illuminated when its respective test button was pushed except for the battery light location installed at the 900 Hall side exit and by the exit door by the "Center". These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 4 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Executive Director, the Housekeeping Manager and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, a total of four battery operated lighting systems were noted in the facility. Each battery operated lighting system illuminated when its respective test button was pushed except for the battery light location installed at the 900 Hall side exit and by the exit door by the "Center". Based on interview at the time of the observations, the Housekeeping Manager and the Maintenance Assistant agreed the aforementioned battery light locations each failed to illuminate when its respective test button was pushed. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)			
K 0321 SS=F 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	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. 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 2 of over 17 hazardous areas such as fuel fired heater rooms and combustible storage rooms/spaces over 50 square feet in size were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Housekeeping Manager and the Maintenance Assistant during a tour of the	K 0321	1. 1. No residents were found to be affected by the alleged deficient practice. A door closure was installed on the electrical/sprinkler room and the gap identified on the center door was properly addressed. 2. 2. All residents have the potential to be affected by the alleged deficient practice. 3. 3. The maintenance staff has been educated on the LSC requirements and NFPA standards regarding validation of smoke resistant separation.	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, the following was noted: a. the entrance door in the door set to the Electrical/Sprinkler Room in the service hall was not equipped with a self closing device. In addition, a 3/4ths inch gap was noted in between the meeting edges of the metal doors in the door set near the floor. b. the entry door to the storage room in the "Center" behind the stage had a two inch in diameter hole in the door near the door handle which would not resist the passage of smoke. The room was being used for storage of combustible boxes and was over 50 square feet in size. Based on interview at the time of the observations, the Maintenance Assistant agreed the aforementioned hazardous areas were not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)		4. 4. Means of egress will be audited weekly to validate that areas are continuously maintained free of obstructions or impediments for emergencies. The quality assurance committee will review the performance improvement tool for compliance and make further recommendations as needed.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen fire suppression systems was inspected semi-annually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect all kitchen staff. Findings include: Based on review of the kitchen fire suppression system inspection contractor's "Semi-Annual Exhaust Hood Fire Suppression System" inspection documentation dated 07/05/22 and "Kitchen Suppression System Inspection" documentation dated 04/18/23 with the Executive Director during record review from 10:15 a.m. to 12:30 p.m. on 08/24/23, documentation of semiannual kitchen fire suppression system inspection six months after 07/05/22 was not	K 0324	1. 1. No residents were found to be affected by the alleged deficient practice. A kitchen hood inspection was completed by Safecare on 8/10/2023. 2. 2. All residents have the potential to be affected by the alleged deficient practice. 3. 3. The maintenance staff has been educated on the LSC requirements and NFPA standards regarding semi-annual kitchen fire suppression system inspections to verify timely completion. 4. 4. The Executive Director will audit Safecare's service and inspection portal monthly to verify inspections have been completed timely and supportive documentation provided.	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	available for review. Based on interview at the time of record review, the Executive Director agreed documentation of semi-annual fire suppression system inspection six months after 07/05/22 was not available for review at the time of the survey. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. NFPA 72, Table 14.4.5 states fire alarm systems, indication and notification appliances shall be functional tested annually. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that	K 0345	1. 1. No residents were found to have been affected by the alleged deficient practice. Safecare completed smoke detector sensitivity testing on 8/31/23. All 2. Residents have the potential to be affected by the alleged deficient practice. 3. 3. The maintenance staff has been educated on the LSC requirements and NFPA standards regarding required smoke detector sensitivity testing to verify timely	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Executive Director from 10:15 a.m. to 12:30 p.m. on 08/24/23, select fire alarm system initiating devices are inspected and tested quarterly such that all devices should be inspected and tested within a rolling twelve month period. However, the review of "Annual Fire Alarm and Signaling Inspection" documentation dated 11/18/22 and 02/01/22 and the review of "Fire Alarm System Inspection" documentation dated 05/17/23 and 07/17/23 indicated not all fire alarm system smoke detector initiating devices were documented as being inspected and tested within the most recent twelve month period. Based on interview at the time of record review, the Executive Director stated the facility switched fire alarm system inspection contractors within the last year and agreed fire alarm system testing documentation within the most recent twelve month period did not indicate all initiating devices were documented as being inspected and tested within the most recent twelve month period. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA		completion. 4. 4. The Executive Director will audit Safecare's service and inspection portal monthly to verify inspections have been completed timely and supportive documentation provided.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Section 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. Section 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Executive Director from 10:15 a.m. to 12:30 p.m. on 08/24/23, smoke detector sensitivity testing documentation for all facility smoke detectors within the most recent two year period was not available for review. Based on interview at the time of record review, the Executive Director stated the facility switched fire alarm system inspection contractors within the last year and agreed smoke detector sensitivity testing documentation for all facility smoke detectors within the most recent two year period was not available for review at the time of the survey. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Exceptional Living Centers "Fire Watch" documentation with the Executive Director during the exit conference from 3:05 p.m. to 4:00 p.m. on 08/24/23, the fire watch plan for fire alarm system impairment was incomplete. The plan stated to call the State Department of Health but failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. Based on interview at the time of the exit conference, the Executive Director stated the plan stated to contact IDOH but the methods of contacting IDOH were not stated in the plan to contact the Indiana	K 0346	1. 1. No residents were found to have been affected by the alleged deficient practice. The Fire Watch Policy for Alarm System Outages was updated to include the primary and secondary methods of notifying IDOH. 1.All residents have the potential to be affected by the alleged deficient practice. 2.The updated policy has been added to the Emergency Preparedness Plans. 3.The quality assurance committee will review and update the Emergency Preparedness Plan and applicable polices at least annually for compliance and make further recommendations as needed.	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	Department of Health at incidents@health.in.gov should the ISDH Gateway link be nonoperational. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinklers were not obstructed in 1 of 1 Activities Storage rooms in the "Center" in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section	K 0351	1. 1. The Activities Storage room was reorganized to ensure the height of storage items were below 18 inches from the sprinkler deflectors. 1.Other storage areas throughout the building were	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Activities Storage rooms in the "Center". Findings include: Based on observations with the Executive Director, the Housekeeping Manager and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, shelf storage was noted in the Activities Storage room in the "Center". The height of the shelf storage was within six inches of the ceiling which obstructed the sprinkler spray pattern of the ceiling mounted sprinkler in the room. Based on interview at the time of the observations, the Maintenance Assistant agreed shelf storage in the room would obstruct the sprinkler spray pattern for the ceiling mounted sprinkler in the room. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)		reviewed to verify that there were no obstructions less than or equal to 18 inches below the sprinkler deflectors. 2.The maintenance staff have been educated on the LSC and NFPA requirements for verifying that facility sprinkler spray patterns were not obstructed as required. 4. 4. Storage areas will be audited monthly to validate that spray patterns for sprinklers are unobstructed. The quality assurance committee will review the performance improvement tool for compliance and make further recommendations as needed.	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	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			
	1. Based on record review, observation, and interview; the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC Section 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. Section 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, Section 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, Section 5.3.3.1 requires the mechanical waterflow alarm devices	K 0353	1a. No residents were found to be affected by the alleged deficient practice. The Dry Pipe Sprinkler Inspection was completed by Safecare on 8/08/2023. 2a. All residents have the potential to be affected by the alleged deficient practice. 3a. The maintenance staff has been educated on the LSC requirements and NFPA standards regarding quarterly dry pipe sprinkler inspections to verify timely completion has occurred. 4a. The Executive Director will audit Safecare's service and inspection portal monthly to verify inspections have been completed timely and supportive documentation provided. 1b. The missing ceiling tiles were replaced and the facility's dry sprinkler system gauges and	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	including, but not limited to, water motor gongs, shall be tested quarterly. NFPA 25, Section 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 09/19/22 and 12/14/22 and "Sprinkler: Report of Inspection" documentation dated 05/18/23 and 08/08/23 with the Executive Director during record review from 10:15 a.m. to 12:30 p.m. on 08/24/23, documentation of a quarterly sprinkler inspection in the first quarter (January, February, March) 2023 was not available for review. Based on interview at the time of record review, the Executive Director stated the facility changed sprinkler inspection contractors within the last year and agreed additional quarterly sprinkler inspection documentation for the most recent twelve month period was not available for review. Based on observations with the Executive Director, the Housekeeping Manager, and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, the sprinkler system inspection contractor had affixed hanging tags to sprinkler system riser locations documenting sprinkler system inspections occurred on 09/19/22, 12/14/22, 05/18/23 and on 08/08/23. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference.		control valves were inspected and maintenance performed as indicated. 2b. All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. 3b. The maintenance staff has been educated on immediate replacement of missing ceiling tiles and the facility's dry sprinkler system gauges, control valves, required inspections and routine maintenance. The Executive Director or designee will complete a weekly audit to validate compliance. 4b. The quality assurance committee will review the performance improvement tool for compliance and make further recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	3.1-19(b) 2. Based on record review and interview, the facility failed to 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 deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Weekly Automatic Sprinkler System Pressure Readings" documentation for the most recent twelve month period with the Executive Director during record review from 10:15 a.m. to 12:30 p.m. on 08/24/23, weekly dry sprinkler system gauge inspection documentation and sprinkler valve inspection documentation after 04/18/23 was not available for review. Based on interview at the time of record review, the Executive Director agreed sprinkler system gauge and control valve inspection documentation after 04/18/23 was not available for review. These findings were reviewed with the Executive			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain the ceiling construction in 2 of over 3 storage rooms in the "Center". NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the Utility Room in the "Center". Findings include: Based on observations with the Executive Director, the Housekeeping Manager, and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, suspended ceiling tiles were not in place in the ceiling of the Utility Room by the restrooms in the "Center" and in the Storage Room in the "Center". Based on interview at the time of the observations, the Maintenance Assistant agreed the missing ceiling tiles would delay activation of the sprinklers located in the rooms. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of 118 of 118 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and	K 0354	1. 1. No residents were found to have been affected by the alleged deficient practice. The Fire Watch Policy for Alarm System Outages was updated to include the primary and secondary methods of notifying IDOH. 1.All residents have the potential to be affected by the alleged deficient practice. 2.The updated policy has been added to the Emergency Preparedness Plans. 3.The quality assurance committee will review and update the Emergency Preparedness Plan and applicable polices at least annually for compliance and make further recommendations as needed.	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on review of Exceptional Living Centers "Fire Watch" documentation with the Executive Director during the exit conference from 3:05 p.m. to 4:00 p.m. on 08/24/23, the fire watch plan for sprinkler system impairment was incomplete. The plan stated to call the State Department of Health but failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. The fire watch plan for sprinkler system impairment also did not state to contact the alarm monitoring company. Based on interview at the time of the exit conference, the Executive Director stated the plan stated to contact IDOH but the methods of contacting IDOH were not stated in the plan to contact the Indiana Department of Health at incidents@health.in.gov should the ISDH Gateway link be nonoperational and to contact the alarm monitoring company. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 33 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the 100 Hall Mechanical Room. Findings include: Based on observations with the Executive Director, the Housekeeping Manager and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, the ABC type portable fire extinguisher located in the 100 Hall Mechanical Room had an affixed maintenance tag by an inspection contractor indicating the date the most recent annual maintenance was performed was February 2022. Based on interview at the time of the observations, the Maintenance Assistant agreed it had been greater than twelve months since the most recent annual maintenance was documented	K 0355	1. 1. No residents were found to have been affected by the alleged deficient practice. The fire extinguisher identified was removed and replaced with a spare that had been inspected as required. Safecare will reinspect the identified fire extinguisher and affix the maintenance tag confirming the inspection. 1.All residents have the potential to be affected by the alleged deficient practice. 2.The maintenance staff has been educated on the LSC requirements and NFPA standards to perform monthly inspections of our fire extinguishers and verify an annual inspection was completed as required. 3.The quality assurance committee will review the performance improvement tool for compliance and make further recommendations as needed.	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	on the aforementioned portable fire extinguisher. These findings were not reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 33 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the 100 Hall Mechanical Room. Findings include: Based on observations with the Executive Director, the Housekeeping Manager and the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, the affixed maintenance tag for the ABC type portable fire extinguisher located in the 100 Hall Mechanical Room had missing monthly inspection documentation for December 2022 through July 2023. Based on interview at the time of the observations, the Maintenance Assistant agreed the aforementioned portable fire extinguisher location had missing monthly inspection documentation for the aforementioned eight month period. These findings were not reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 5 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Housekeeping Manager and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, the following was noted: a. the corridor door to the 100 Hall Unit Manager's office was propped in the fully open position with a wedge placed on the floor under the door. b. the corridor door to the kitchen labeled as the	K 0363	1. 1. No residents were found to be affected by the alleged deficient practice. The doors identified were addressed immediately during the survey. 2. 2. All residents have the potential to be affected by the alleged deficient practice. 3. 3. Facility staff have been educated on the LSC requirements and NFPA standards regarding the requirement to ensure corridor doors were not impeded to closing and latching into the door frames. 4. 4. Corridor doors will be audited weekly to validate that doors are continuously maintained	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	"Kitchen-out" door was propped in the fully open position with a plastic cup lid placed on the floor under the door. c. the corridor door to the kitchen listed as the "Kitchen-in" was not equipped with a positive latching device to latch the door into the door frame. d. the corridor door to the 300 Hall Ice Room and the corridor door to Room 308 were each propped in the fully open position with a trash can placed up against the door. Based on interview at the time of the observations, the Executive Director and the Maintenance Assistant agreed the aforementioned corridor doors each had an impediment to closing and latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b)		free of obstructions or impediments to prevent proper closing and latching into the door frames. The quality assurance committee will review the performance improvement tool for compliance and make further recommendations as needed.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the	K 0712	1. 1. No residents were found	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	facility failed to provide documentation of a fire drill conducted on the third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" with the Executive Director during record review from 10:15 a.m. to 12:30 p.m. on 08/24/23, documentation of a fire drill conducted on the third shift in the third quarter (July, August, September) 2022 was not available for review. Based on interview at the time of record review, the Executive Director stated the facility operates three shifts per day and agreed documentation of a fire drill conducted on the third shift in the third quarter 2022 was not available for review. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b) and 3.1-51(c) 2. Based on record review and interview, the facility failed to document activation of the fire alarm system on fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.		to have been affected by the alleged deficient practice. 2. 2. All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Fire drills continue to be conducted on all shifts at unexpected times under various conditions. 3. 3. The maintenance staff have been educated on the requirements of conducting monthly fire drills at unexpected times under various conditions. The administrator or designee will complete a monthly audit to validate ongoing compliance. 1.The quality assurance committee will review the performance improvement tool for compliance and make further recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" with the Executive Director during record review from 10:15 a.m. to 12:30 p.m. on 08/24/23, documentation for the second shift fire drill conducted on 05/22/23 at 6:00 p.m. indicated the drill was conducted after 6:00 a.m. but before 9:00 p.m. and did not document activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. The aforementioned second shift fire drill documentation stated "Silent Drill". Based on interview at the time of record review, the Executive Director stated the facility operates three shifts per day and agreed documentation for the aforementioned second shift fire drill conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill. These findings were reviewed with the Executive Director and the Vice President of Plant Operations during the exit conference. 3.1-19(b) 3.1-51(c)			
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure unattended soiled linen and trash receptacles in 2 of over 10 means of egress were stored in a room protected as a hazardous area in accordance with Section 19.7.5.7. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Housekeeping Manager and the Maintenance Assistant during a tour of the facility from 12:30 p.m. to 3:05 p.m. on 08/24/23, one unattended partially filled soiled linen cart and one unattended partially filled trash cart were stored next to one another in the corridor outside resident sleeping Room 114 and outside the 300 Hall Ice Room. The combined capacity of the two carts at each location exceeded 32 gallons. Based on interview at the time of the observations, the Housekeeping Manager agreed the aforementioned soiled linen and trash carts were not being stored in a room protected as a hazardous area when unattended and had staff remove the carts from the corridor. These findings were reviewed with the Executive Director and the Vice President of Plant	K 0754	1. 1. No residents were found to be affected by the alleged deficient practice. The linen and trash containers were placed into the utility room. 2. 2. All residents have the potential to be affected by the alleged deficient practice. 3. 3. Facility staff have been educated on the LSC requirements and NFPA standards regarding the requirement to ensure linen and trash containers are kept in the utility room when not being utilized during care rounds. 4. 4. Corridors will be audited weekly to validate that unattended linen and trash containers are properly stored in the hallway utility rooms as required. The quality assurance committee will review the performance improvement tool for compliance and make further recommendations as needed.	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 01 B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	Operations during the exit conference. 3.1-19(b)			