

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on June 14, 2016.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00204315 and IN00204069.</p> <p>Survey dates: August 1 & 2, 2016.</p> <p>Facility number: 000175 Provider number: 155275 AIM number: 100274440</p> <p>Census bed type: SNF/NF: 78 Total: 78</p> <p>Census payor type: Medicare: 9 Medicaid: 62 Other: 7 Total: 78</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>F-000 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: August 24, 2016. Facility is respectfully requesting paper compliance for all deficiencies in this POC.</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/02/2016
---	--	---	--

NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed by #02748 on August 9, 2016.			
F 0364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/02/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	<p>PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, interview, and record review, there facility failed to provide food at the proper temperature and palatable and attractive for 1 of 2 meal observations.</p> <p>Findings include:</p> <p>During an interview on 8/1/16 at 10:52 a.m., Resident A indicated the food was not very good at the facility. The resident indicated he did not always eat the food that was on the menu and would often have peanut butter and jelly sandwiches for his meals.</p> <p>During an observation on 8/1/16 at 11:45 a.m., the goulash on the serving table appeared watery with little tomato sauce present. A container of plain macaroni also was observed to be sitting on the steam table. Cook #1 indicated the plain macaroni on the steam table was present in case she needed to add macaroni to the goulash. The broccoli appeared to be mainly stems that were served to the residents.</p>	F 0364	<p>F-364 It is the policy of the facility to see that food served is prepared by methods that conserve nutritive value, flavor and appearance. Also, food is to be palatable, attractive and at the proper temperature. Residents A, H and I are well satisfied with the meals/food served at the facility. Foods like goulash that require a sauce(such a tomato sauce) have adequate amounts of ingredients to make the dishes tasty, flavorful and "hearty" so as to be desirable to the residents. Vegetables like broccoli, are served with florets and/or desirable cuts to make them more appetizing and palatable for the residents. Nutritious, attractive and palatable substitutes (at proper temps) are offered to residents who do not desire to eat the menu meals. Foods are temped by the appropriate kitchen staff prior to plating the food for serving and resident consumption. Residents who consume food/meals prepared by the facility have the potential to be affected by the finding. All foods (bulk amount) will be temped prior to being plated for service. The temps will be taken/logged by the</p>	08/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/02/2016
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>During an observation on 8/1/16 at 12:05 p.m., Resident H and Resident I were observed to be seated at the dining room table on the locked dementia care unit. Resident H and Resident I indicated the food looked terrible and was unfit to eat. Resident H indicated it was probably made with left-overs with Resident I in agreement.</p> <p>During an interview on 8/1/16 at 2:30 p.m., an anonymous family member indicated the food which was served would often be unidentifiable. The family member indicated the food was not appealing in appearance and the staff would oftentimes obtain a peanut butter sandwich for the residents.</p> <p>During an interview on 8/2/16 at 8:40 a.m., LPN #1 indicated if a resident did not want the food on the menu, she would go to the kitchen and obtain peanut butter and jelly sandwiches for the resident. LPN #1 indicated the residents always received another food if they did not like the food being served.</p> <p>During an observation on 8/1/16 at 11:45 a.m., Cook #1 was observed to place a bowl of goulash and a bowl of broccoli onto a plate. Cook #1 was observed to place the plate onto the tray. Cook #1 was observed to do this for 2 (two)</p>		<p>cook/designee. The Dietary Manager/Designee will monitor the temp logs daily to see that temps are taken and logged and that they fall within the acceptable temp parameters as per policy and state guidelines for food temps. Foods will be served at proper temps. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. After that, the monitoring will occur 3 days weekly to ensure continued compliance. Further, the DON/Designee will temp the last tray cart tray on each of the 3 main areas besides the Main Dining Room which includes Hope Springs, Rehab and Skilled to monitor for acceptable food temps. If the temps are not acceptable, this will be corrected prior to serving. This monitoring will take place 3 days weekly at various meals. This will include some weekend days. Further, during the monitoring of temps, 3 interviewable residents in each area (Hope Springs, Rehab and Skilled) will be interviewed as to satisfaction with appearance, palatability, flavor and temp of food/meals. Any concerns will be addressed as discovered. The monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. After that, the monitoring will occur 1 day weekly ongoing to ensure continued compliance. The Administrator will review the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/02/2016	
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>different resident trays. Upon query, Cook #1 indicated she had not obtained the temperature of the foods prior to traying the foods. Cook #1 indicated she would "do it now if I wanted." Cook #1 proceeded to temp the food at that time. While temping the foods, a container of plain macaroni was observed to be on the steam table. Upon query, Cook #1 indicated the plain macaroni was to add to the goulash if she needed it or if a resident preferred plain macaroni, she would have it.</p> <p>During an interview with LPN #1 on 8/2/16 at 10:56 a.m., LPN #1 indicated Resident H and Resident I complain often about different things on the unit. LPN #1 indicated Resident I was a "picky" eater, so she asked for and received substitutes often. LPN #1 indicated she had obtained substitute foods for Resident H at times also, but not as often as Resident I.</p> <p>During an interview on 8/2/16 at 845 a.m., the Adm (Administrator) indicated she had educated Cook #1 regarding the temping of the foods and when the temping should occur.</p> <p>During an interview on 8/2/16 at 1:45 p.m., the Adm indicated she would be going over the menu more thoroughly to</p>		<p>menus/recipes monthly with the Dietary Manager and the Dietician prior to the roll out to ensure that menus include substantial amounts of sauces in the entrees as well as quality cuts of vegetables (such as broccoli florets instead of all stems and pieces). Further, at this time, review of the quality of the substitutes available will be verified. Any concerns will be corrected prior to roll out. This will be an ongoing process. At an in-service held for dietary on 8-3-2016, the following was reviewed: A.) Meals/Food—Nutrition Appearance Palatability Temps B.) Temping food prior to serving—Who? When? How? Logged? Acceptable Temps-- -What are the parameters? What to do if outside the parameters? C.) Foods-- -Storage/Labels/Dates D.) Infection Control—Hand Hygiene during mealprep and service 3Compartment Sink—proper use of Hair covering in Dietary Dept. Crosscontamination—Ex: Items like mitts coming in contact with foods What to do if you see a "breach" At an in-service held on 8-19-2016 for all staff the following was reviewed: A.) Importance of timely tray service B.) What to do if a resident complains about the food including flavor, palatability and temp C.) Substitute meals/foods—when to offer and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/02/2016
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 0371 SS=E Bldg. 00	<p>see what the facility was going to be serving to the residents each month to ensure the menu would be what the residents would want to eat.</p> <p>A policy, dated 2011 and obtained from the DM (Dietary Manager) on 8/2/16 at 2:00 p.m., indicated the cook will take the temperatures of hot and cold food items would be obtained prior to each meal service.</p> <p>This deficiency was cited on 6/14/16. The facility failed to follow their plan of correction to provide palatable food to the residents.</p> <p>3.1-21(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p>		<p>how to obtain D.) Proper hand hygiene during meal service and delivery of trays E.) Questions/Answers Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meeting, the results of the monitoring by the Dietary Manager/Designee and the DON/Designee will be reviewed for any patterns. If necessary, an Action Plan will be written by the committee. Any Action Plan will be reviewed by the Administrator weekly until resolution.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to prepare and serve food under sanitary conditions for 1 of 2 observations of the kitchen.</p> <p>Findings include:</p> <p>During an observation of the kitchen on 8/1/16 at 8:55 a.m., the walk-in freezer had a plastic bag of broccoli stems and cuts, with the bag opened and undated.</p> <p>During an observation on 8/1/16 at 11:26 a.m., Cook #1 was observed to puree goulash and broccoli for the noon meal. Cook #1 was observed to obtain the goulash from a pan and place it into the food processor. Cook #1 added "a little bit" of tomato sauce to the goulash to puree it. The pureed goulash was placed into a pan and covered with foil. Cook #1 reached into her pocket and retrieved a marker to date and label the goulash prior to placing it into the oven. Cook #1 removed the processor from the base, and rinsed the lid and blade off in the 3-compartment sink with water only.</p>	F 0371	<p>F-371</p> <p>It is the policy of the facility to ensure that food is prepared and served under sanitary conditions. All foods in the walk-in freezer are properly sealed (stored)/labeled and dated. No staff reach into their pockets to retrieve markers to date food covers. All equipment is cleaned properly and appropriately as per policy as far as what is in the 3 compartment sinks (soap/chemicals/water as indicated) and when it is to be discarded as well as show equipment is introduced and extracted as related to the 3 compartment sink. The 3 compartment sink sides are not to be used for draining liquid from pans. Proper hand hygiene is practiced in the Dietary Department. Hair nets/covers are worn by</p>	08/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/02/2016	
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Cook #1 rinsed the processor bowl under running water without soap, obtained a used metal scrub pad and cleaned the inside of the bowl out, and rinsed the bowl under running water again. Cook #1 indicated she had discarded the sanitizing water in the 3 - compartment sink earlier and had not made anymore.</p> <p>After pureeing the goulash, Cook #1 obtained a pan containing broccoli in water from the stove, Cook #1 emptied the water from the pan using the side of one of the 3 - compartment sinks to assist with draining the broccoli. Cook #1 placed 6 (six) scoops of broccoli into the processor and pureed the broccoli. Cook #1 placed the pureed broccoli into a smaller pan and covered it what aluminum foil. She then obtained a marker from her pocket to date and label the pureed broccoli prior to placing it into the oven.</p> <p>No hand hygiene was observed prior to, during, or after pureeing the goulash or the broccoli.</p> <p>During an observation on 8/1/16 at 11:25 a.m., the Dietary Manager was observed to be dishing up cake for the noon meal. The DM had hair hanging out of the right side of her hair restraint.</p>		<p>staff/otherswhile in the Dietary Department. Ovenmitts do not come into contact with food. Any staff who deliver food/drink to residents including Resident K haveproper hand hygiene practiced for them as their food/drink is delivered. The DM will monitor forproper food labeling/dating/storage in the freeze 5 days weekly. Further, the DM will monitor to see thatproper hand hygiene takes place in the Dietary Department. This will take place during the preparationand serving of meals 3 days weekly. These will be on various meals and will include some weekend days. Also, the use of the 3 compartment sink will bemonitored 3 days weekly for proper use and contents of the compartments(including discarding appropriately). The use of the hand mitts (not coming into contact with food) as well asproper hair covering will also be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/02/2016	
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>During an observation on 8/1/16 at 11:30 a.m., Cook #1 was observed to apply oven mitts to both hands, obtained a pan of goulash from the oven, and placed it on the serving table ledge. Cook #1 removed the foil and attempted to place the pan into the steam table area. Cook #1 was observed to place her thumbs with the mitts on into the goulash pan. Cook #1 indicated she had gotten "sauce all over" the mitts.</p> <p>During an observation on 8/1/16 at 12:12 p.m., Activity Aide (AA) #1 was observed to be serving drinks in the main dining room. AA #1 was observed to have gloves on both hands. AA #1 was observed to open a straw for Resident J, handling the entire straw. AA #1 was observed to move Resident K to the table in her wheelchair. AA #1 was observed to obtain a cup of coffee for Resident K and handled the cup by the rim when serving it to the resident. AA #1 was observed to wear the same pair of gloves.</p> <p>During an interview on 8/2/16 at 2:15 p.m., the Registered Dietician indicated sanitizing water should of been used during the washing of the processor.</p> <p>A policy, dated 2011 and obtained from the Registered Dietician on 8/2/16 at 2:25 p.m., indicated all equipment would be</p>		<p>monitored 3 days weekly at various meals and will include some weekend days. The DON/Designee will monitor the delivery of trays in the dining room as well as other areas where trays are delivered 3 days weekly to see that proper hand hygiene occurs before, during and after trays are served as indicated. Any concerns encountered during the monitoring will be corrected as found. The monitoring by the Dietary Manager will continue until 4 consecutive weeks of zero negative findings are achieved. After that, monitoring will occur 3 days weekly ongoing to ensure continued compliance. The monitoring by the DON/Designee will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, the monitoring will continue at least 1 day weekly ongoing to ensure continued compliance. At an in-service held</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>washed in a hot detergent solution in the first compartment of the 3-compartment sink, rinsed well in the second compartment, and sanitized by either heat or chemicals in the third compartment.</p> <p>This deficiency was cited on 6/14/16. The facility failed to follow their plan of correction to prepare and serve food under sanitary conditions to the residents.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>on8-3-2016 for the dietary staff the following was reviewed:</p> <p>At an in-service held on8-19-2016 for all staff the following was reviewed:</p> <p>Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated.</p> <p>At the monthly QA meetings, the results of the monitoring by the DM/Designee and also by the DON/Designee will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written. Any written Action Plan will be monitored weekly by the Administrator until resolution.</p> <p>Date of Compliance 8-24-2016</p>	

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

PRINTED: 08/26/2016

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/02/2016
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	