

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/29/2016
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NAME OF PROVIDER OR SUPPLIER  WATERS OF PRINCETON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/29/16</p> <p>Facility Number: 000175 Provider Number: 155275 AIM Number: 100274440</p> <p>At this Life Safety Code survey, The Waters of Princeton was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 95</p>	K 0000	<p>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.</p> <p><b>Facility is respectfully requesting paper compliance for all deficiencies in this POC.</b></p>	
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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.

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K 0015 SS=B Bldg. 01	<p>and had a census of 79 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one detached wood shed and one detached metal pod, both structures used for facility storage.</p> <p>Quality Review completed on 07/01/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of laundry rooms was provided with a complete interior finish with a flame spread rating of Class A, Class B or Class C for a sprinklered facility. This deficient practice could affect laundry only.</p> <p>Findings include:</p> <p>Based on observation on 06/29/16 at 11:50 a.m. during a tour of the facility</p>	K 0015	<p>K0015 It is the intent of this facility to ensure 1 laundry room is provided with a complete interior finish with a flamespread rating of Class A, Class B or Class C for a sprinklered facility. This deficient practice could affect laundry only. 1. ACTIONS TAKEN: A: Maintenance immediately replaced the hole in the ceiling with drywall according to NFPA Standards. 2. RESIDENTS AFFECTED: A: This deficient practice could affect laundry only. 3. MEASURES</p>	07/15/2016

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	<p>with Maintenance Assistant #1, there was a three foot by three foot section of the laundry room ceiling covered with plywood. The plywood was covering holes that penetrated the ceiling. This was acknowledged by Maintenance Assistant #1 at the time of observation, furthermore, Maintenance Assistant #1 said the plywood did not have a flame spread rating.</p> <p>3.1-19(b)</p>		<p>TAKEN A: Facility Maintenance staff immediately replaced the board with drywall. The drywall was secured and sealed preventing any heat or smoke loss in the event of a fire. 4: HOW MONITORED: A: The facility has an outside monitoring company which monitors the fire alarm system 24 hours a day. The facility also performs regular monthly fire drills covering all three shifts. B: The Administrator/Designee will monitor the laundry room for any holes in the ceiling drywall. This monitoring will continue until 6 consecutive months of zero negative findings is achieved. After that, random monitoring will occur. At an in-service held for all staff July 6, 2016, the following was reviewed: A.) NFPA standards related to drywall and holes in drywall. B.) How to monitor for holes in drywall and correctly fix any hole per NFPA standards. C.) 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 meetings the results of the monitoring will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator weekly until resolution. Note: Any concerns will have been</p>		

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K 0144 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on record review and interview, the facility failed to ensure there was documentation 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p>	K 0144	<p>corrected immediately as found. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.</p> <p>K0144 It is the intent of this facility to ensure there is documentation showing emergency generators are allowed a 5 minute cool down period after a load test. 1. ACTION TAKEN: A: Maintenance immediately provided a standard Generator Test Form which includes an area where the 5-minute cool down period is clearly documented. 2. RESIDENTS AFFECTED: A: This deficient practice could affect all residents, as well as staff and visitors in the facility. 3. MEASURES TAKEN A: Maintenance immediately provided a standard Generator Test Form which includes an area where the 5-minute cool down period is clearly documented. A copy of the form used is provided with this Plan of Correction. 4: HOW MONITORED A: The Administrator/Designee will monitor Generator Tests monthly to ensure the generator is given a 5 minute cool down after a load</p>	07/15/2016

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	<p>Based on review of the facility's emergency generator monthly load test log on 06/29/16 at 10:45 a.m. with Maintenance Assistant #1 present, the generator log form documented the generator was tested monthly for 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. During an interview at the time of record review, Maintenance Assistant #1 confirmed the monthly generator log did not include documentation of a cool down time being recorded.</p> <p>3.1-19(b)</p>		<p>test. Further, the Administrator/Designee will monitor to ensure the Generator Test form provided is being completed appropriately to include documentation of the 5 minute cool down is being performed. This monitoring will continue until 6 consecutive months of zero negative findings is achieved. After that, random monitoring will occur. At an in-service held for all staff July 6, 2016, the following was reviewed: A.) Generator Test Log B.) How to complete a generator test C.) 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 meetings the results of the monitoring will be reviewed. Any patterns will be identified. If necessary, an ActionPlan will be written by the committee. Any Action Plan will be monitored by the Administrator weekly until resolution. Note: Any concerns will have been corrected immediately as found.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		