

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 04/04/2014
--	---	--	---

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
K010000	<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: 04/03/14 and 04/04/14</p> <p>Facility Number: 000175 Provider Number: 155275 AIM Number: 100274440</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Princeton was found not in 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 in spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 97 and had a census of 72 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except one detached wood shed and one detached</p>	K010000	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. The facility request paper compliance for this survey.	

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 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/04/2014
--	---	--	---

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
K010017 SS=E	<p>metal pod, both structures used for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 open use areas were separated from the corridor by walls which resist the passage of smoke, or met an Exception. LSC 19.3.6.1, Exception #1, Smoke compartments protected throughout by an approved, supervised automatic sprinkler system shall be permitted to have spaces unlimited in size open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas.</p>	K010017	<p>This facility is requesting paper compliance for this survey. K 017 NFPAA 101 Life Safety Code Standard A. ACTIONS TAKEN: No residents were found to have been affected however all resident's had the potential to be affected. A smoke detector was installed in designated area. B. OTHERS IDENTIFIED: All resident's had the potential to be affected however no residents were affected. C. MEASURES TAKEN: Maintenance will</p>	05/04/2014

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 04/04/2014
--	---	--	---

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
K010029 SS=B	<p>(b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, or the smoke compartment in which the space is located is protected throughout by quick response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect 16 residents, as well as staff and visitors in the Crossings Unit.</p> <p>Findings include:</p> <p>Based on observation on 04/04/14 at 10:50 a.m. during a tour of the facility with the Maintenance Supervisor, the Crossings dining room was open to the corridor. Exception #1 requirement (c) of LSC 19.3.6.1 was not met as follows: The Crossings dining room was not protected by an electrically supervised automatic smoke detection system, and the entire space was not arranged and located to allow direct supervision by the facility staff from nurses' stations or similar staffed space. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3-1.19(b) NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the</p>		<p>assure that the smoke detector is maintained and serviced as required by NFPA. Log will be kept to identify compliance. D.</p> <p>HOW MONITORED: 1. The Administrator will review maintenance log on a monthly basis. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring.</p>	

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 04/04/2014
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>approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 shower rooms which contained soiled linen and trash containers over 32 gallons in capacity was equipped with a positive latching door. This deficient practice could affect up to 16 residents, as well as staff and visitors in the Crossings Unit.</p> <p>Findings include:</p> <p>Based on observation on 04/04/14 at 11:10 a.m. during a tour of the facility with Maintenance Supervisor, the Crossings Unit shower room door was not equipped with a positive latching door. At the time of observation there were two large rubber barrels over 32 gallons each which were half full of soiled linen and trash. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010029	<p>This facility requests paper compliance for this survey. K 029 NFPA 101 Life Safety Code</p> <p>A. ACTIONS TAKEN:</p> <p>No residents were found to have been affected.</p> <p>Linen and Trash barrels were removed from the Crossings shower room .</p> <p>B. OTHERS IDENTIFIED:</p> <p>All residents had the potential to be affected. No resident's had been affected.</p> <p>100% audit was completed at the time of the Occurrence. No other residents were affected.</p> <p>C. MEASURES TAKEN:</p> <p>1. An in-service was conducted with the nursing and</p>	05/04/2014	

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 04/04/2014
--	---	--	---

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
K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 7 exits was maintained to provide safe access to the</p>	K010038	<p>QMA staff reeducating on the Policy and Procedure for policy and procedure on storage of linen and trash.</p> <p>D. HOW MONITORED:</p> <p>1. Housekeeping Director or designee will monitor the shower rooms at least 3 times weekly to ensure proper storage of trash and linens. Any negative findings will be immediately addressed.</p> <p>2. The Administrator/Designee will review the audits weekly for at four consecutive weeks of no negative findings. Random monitoring thereafter. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring.</p> <p>This facility request paper compliance for this survey. <u>K 038 NFPA 101 LIFE SAFETY CODE STANDARD</u></p>	

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 04/04/2014
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>public way in accordance with LSC Section 7.1. LSC Section 7.1.6.3 requires walking surfaces shall be nominally level. This deficient practice could affect up to 16 residents, as well as staff and visitors in the Crossings Unit during an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 04/04/14 at 10:55 a.m. during a tour of the facility with the Maintenance Supervisor, the 175 foot long asphalt sidewalk between the Crossings Unit northwest exit and the northeast parking lot (public way) was uneven and cracked, with dips and gaps across the entire length of the sidewalk. This could create a trip hazard and would be very difficult to traverse with a wheelchair or bed in the event of an emergency evacuation. Furthermore, towards the end of the sidewalk and close to the public way there was a grill, smoke tower, and two chairs setting on the sidewalk and blocking the path to the public way. This would also make it difficult to traverse with a wheelchair or bed in the event of an evacuation to get to the public way. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the items on the sidewalk and that the sidewalk would be difficult to traverse in the event of an emergency evacuation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 8 exit doors which was provided with an access controlled egress door with a locking device connected to the fire alarm system, automatically unlocked when the door was pushed for fifteen seconds, pushed the five digit code on</p>		<p>A. ACTION TAKEN:</p> <ol style="list-style-type: none"> No residents have been affected. Asphalt sidewalk resurfaced to assure a smooth pathway. All identified items obstructing the pathway were removed. Key pad and mag lock were wired into the fire alarm panel to allow unobstructed egress in the event of a fire. <p>B. OTHERS IDENTIFIED:</p> <ol style="list-style-type: none"> All residents had the potential to be affected. Those residents were not determined to be negatively affected. <p>C. MEASURES TAKEN:</p> <ol style="list-style-type: none"> Asphalt sidewalk resurfaced to assure a smooth pathway. All identified items obstructing the pathway were removed. Key pad and mag lock 		

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 04/04/2014	
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 key pad next to the exit door, or the fire alarm system was actuated. LSC Section 19.2.1 refers to LSC Chapter 7. LSC 7.2.1.6.2(d) requires activation of the building fire protection signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire protective signaling system has been manually reset. LSC 19.2.2.2.5 states doors located in the means of egress that are permitted to be locked under other provisions of this chapter shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to keys carried by staff at all times, or other such reliable means available to the staff at all times. Only one such locking device shall be permitted on each door. This deficient practice could affect up to 16 residents, as well as staff and visitors in the Crossings Unit.</p> <p>Findings include:</p> <p>Based on observation on 04/04/14 at 11:30 a.m. during a tour of the facility with the Maintenance Supervisor, the entrance/exit door for the Crossings Unit on the west nurses' station side was equipped with an access controlled egress locking device. This door did release from the magnetic holder when the five digit code was pushed, however, the door did not release from the magnetic locking device when the fire alarm system was tested. This was acknowledged by the Maintenance Supervisor at the time of observation and fire alarm testing, furthermore, when asked, the Maintenance Supervisor said the door would have stayed locked even if the fire alarm had been tested by sprinkler or smoke detector activation.</p>		<p>were wired into the fire alarm panel to allow unobstructed egress in the event of a fire.</p> <p>D. HOW MONITORED:</p> <p>As part of the facility Preventative Maintenance Program, the Maintenance Director or designee will monitor weekly and any unsmooth surface will be corrected immediately. The security mag locks and alarms are inspected weekly to ensure they are in working order. Any negative findings will be immediately addressed.</p>				

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 04/04/2014
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	
K010046 SS=E	<p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure the exterior exit discharge path for 1 of 7 emergency exits was provided with emergency powered egress lighting. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including walkways leading to a public way. This deficient practice could affect up to 16 residents, as well as staff and visitors in the Crossings Unit in the event of an emergency evacuation.</p> <p>Findings include:</p> <p>Based on observation on 4/03/14 at 11:00 a.m. during a tour of the facility with the Maintenance Supervisor, there were two separate lights on the exterior wall of the Crossings Unit section. These lights were more than 50 feet away from the 175 foot side walk between the Crossings Unit exit and the northeast parking lot. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the two lights on the exterior wall of the Crossings Unit would probably not light up the entire length of the 175 foot side walk and when asked, said the two lights were not connected to the emergency generator.</p> <p>3.1-19(b)</p>	K010046	<p>The facility requests paper compliance for this survey. K046 LIFE SAFETY CODE STANDARD</p> <p>A. ACTION TAKEN:</p> <p>No residents were found to have been affected.</p> <p>Lighting was installed to illuminate egress pathway appropriately.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. No residents with negative findings were found.</p> <p>C. MEASURES TAKEN:</p> <p>Lighting was installed to illuminate egress pathway appropriately. All other egress lighting was in working order.</p> <p>D. HOW MONITORED:</p> <p>Maintenance Director or designee</p>		

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 04/04/2014
--	---	--	---

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
K010069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is</p>	K010069	<p>will monitor egress lighting as part of the preventative maintenance program. This monitoring will take place 1x weekly to assure compliance. Any negative findings will be addressed.</p> <p>Administrator will review the preventative maintenance log at the facility monthly QA meeting to assure compliance.</p> <p>The facility requests paper compliance for this survey. <u>K 069 NFPA 101 LIFE SAFETY CODE STANDARD</u></p> <p>-</p> <p>A. ACTIONS TAKEN</p> <p>Hood has been cleaned and documentation is presents.</p> <p>B. OTHERS IDENTIFIED:</p> <p>No other residents were affected.</p> <p>C. MEASURES TAKEN:</p> <p>As part of the preventative maintenance program, the Maintenance Director or designee will keep a log to identify when</p>	

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 04/04/2014
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>cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect mostly kitchen staff.</p> <p>Findings include:</p> <p>Based on review of the kitchen range inspection reports in the Inspections Book on 04/04/14 at 10:55 a.m. with the Maintenance Supervisor present, there was no documentation to show the kitchen range hood had been inspected twice within the past twelve months. The only kitchen range hood inspection report was dated 08/25/13. This was acknowledged by the Maintenance Supervisor at the time of record review. Based on observation at 11:45 a.m. on 04/04/14 during a tour of the facility with the Maintenance Supervisor, there was only one date (08/25/13) on the sticker on the kitchen range hood to indicated the range hood had been inspected. This was confirmed by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>hood has been serviced and monitor for compliance.</p> <p>D. HOW MONITORED:</p> <p>The Preventative Maintenance Program will log the semiannual hood inspections. The Maintenance Director will monitor for compliance.</p> <p>Administrator will review the Preventative Maintenance Logs at the facility QA meeting each month to assure compliance. Any negative findings will be addressed by a plan of action written by the Interdisciplinary Team.</p>		