STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155275	A. BUILDING -- B. WING	11/14/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/14/24 Facility Number: 000175 Provider Number: 155275 AIM Number: 100274440 At this Emergency Preparedness survey, The Waters of Princeton was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 95 certified beds and had a census of 60 at the time of this visit. Quality Review completed on 11/22/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	We are requesting a desk review.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Based on record review and interview, the facility failed to ensure a passing annual fuel quality test was performed for 1 of 1 diesel powered generator.	E 0041	**E041**– It is the intent of the facility to ensure a passing annual fuel quality test is performed for the diesel powered generator to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 9-30-2024 the facilities generator contractor removed all the current fuel and cleaned the	12/06/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

andrew grubb | rdo | 12/09/2024

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	NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 11/14/24 between 10:00 a.m. and 2:15 p.m. with the Maintenance Director present, there was a documented annual fuel quality test for the diesel generator available for review, which was dated 9/30/24. The comments section of the report stated "SUGGEST investigating source of CONTAMINATION. WATER and/or SEDIMENT exceeds ASTM specification and can cause corrosion, fuel system component wear, reduce filter life and promote microbiological growth. Water exceeds ASTM specifications. SUGGEST investigating the source of CONTAMINATION. Water can cause SMOKING, fuel system component WEAR and CORROSION, reduce FILTER LIFE and promote MICROBIOLOGICAL GROWTH." Based on interview at the time of record review, the Maintenance Director said another diesel fuel sample was taken on 11/08/24 after the old fuel was removed and replaced, but the facility has not yet received the most recent fuel sample results. This finding was reviewed with the Administrator and Maintenance Director during the exit		tank and refilled the tank with new fuel. Also the new fuel was retested and it passed and the documentation is in the Life Safety Binder to meet set standards. The Administrator verified the work on 9-30-2024 .**ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **2 MEASURES TO PREVENT REOCCURRENCE**: a On 1-27-2024 The Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure a passing annual fuel quality test is performed for the diesel-powered generator to meet set standards. b The Maintenance Supervisor/designee will ensure a passing annual fuel quality test is performed for the diesel-powered generator as a part of the facility's annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place.	

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	conference.		**3 MONITORING CORRECTIVE ACTION**: a At least every month the load bank testing will be completed, and weekly inspection of the generator will be conducted to ensure compliance; the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12-6-2024.**	
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	We are requesting a desk review.	

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	Survey Date: 11/14/24 Facility Number: 000175 Provider Number: 155275 AIM Number: 100274440 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 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and 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 alarms in all resident sleeping rooms. The facility has a capacity of 95 and had a census of 60 at the time of this survey. 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. Quality Review completed on 11/22/24			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on record review, observation, and interview; the facility failed to ensure documentation was provided for the testing of 7 of 7 battery powered emergency light units that were tested monthly for 30 seconds during 3 of	K 0291	**K291** – It is the intent of the facility to ensure documentation is provided for the testing of the battery powered emergency light units that are tested monthly for	12/06/2024

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	the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires 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, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (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, as well as staff and visitors in the facility. Findings include: Based on record review on 11/14/24 between 10:00 a.m. and 2:15 p.m. with the Maintenance Director present, the facility's preventative maintenance report indicated the 7 battery powered emergency light units were tested monthly for 30 seconds, however, there were no 30 second tests performed during December 2023, and January and February of 2024. Furthermore, there was no documentation available to show the battery powered emergency light units were tested annually for 90 minutes during the past 12 month period. Based on observations on 11/14/24 between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, there were 7 battery powered emergency light units observed. Based on an interview at the time of record review, the Maintenance Director stated there were no monthly 30 second tests performed during December 2023, and January and February of 2024, and no 90 minute test performed during		30 seconds and annually for 90 minutes to ensure the light would provide lighting during periods of power outages to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 11-30-2024 the Maintenance Supervisor/designee conducted the monthly 30 second testing and the 90 minute annual testing of the battery powered emergency lights and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work on 11-30-2024 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 11-27-2024the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure to provide and maintain battery powered emergency lights including conducting the monthly 30 second testing and the 90 minute annual testing and document the results in the Life Safety Binder to meet set standards. 2.Maintenance Supervisor/designee will ensure to provide and maintain battery	

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	the past 12 month period on the 7 battery powered emergency light units. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		powered emergency lights including conducting the monthly 30 second testing and the 90 minute annual testing and document the results in the Life Safety Binder as a part of the facility's monthly Preventive Maintenance Program and document those tests on the Battery-Operated Emergency Lights and signs Test Log to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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			This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12-6-2024.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 1 door to a courtyard could not be mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8 inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect residents in the Memory Care Unit. Findings include: Based on observations on 11/14/24 between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the Memory Care Unit's outside door to the courtyard was not posted with a NO EXIT sign. Based on interview at the time of the observation, the Maintenance Director said this door was not a required exit and agreed there should be a "NO EXIT" sign on the door. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0293	**K293**– It is the intent of the facility to ensure door to a courtyard could not be mistaken as a facility exit to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 11-19-2024 the Maintenance Supervisor/designee installed a “No Exit” sign on the Memory Care Unit’s outside door to the courtyard to meet set standards. The Administrator verified the work on 11-19-2024 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 11-27-2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure doors are marked accordingly and not mistaken as a facility exit to meet set standards. b Maintenance Supervisor/designee will ensure	12/06/2024

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			doors are marked accordingly and not mistaken as a facility exit as a part of the facility's monthly Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12-6-2024.**	

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K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other 1. Based on record review, observation, and interview; the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was available for 2 of 12 months. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 11/14/24 between 10:00 a.m. and 2:15 p.m. with the Maintenance Director present, the facility was able to provide a preventative maintenance report that all resident room battery powered smoke alarms were tested on a monthly basis, however, there were no tests performed during January and February of 2024. This was confirmed by the Maintenance Director at the time of record review. During a tour of the facility with the Maintenance Director between 2:15 p.m. and 4:30 p.m., all resident sleeping rooms were observed equipped with battery powered smoke alarms. This finding was reviewed with the Administrator	K 0300	**K300**– It is the intent of the facility to ensure documentation for the preventative maintenance of battery operated smoke alarms in resident rooms is available and to ensure resident room battery operated smoke alarms are maintained to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On the Maintenance Supervisor/designee performed the monthly testing of the resident room battery operated smoke alarms in all resident rooms to meet set standards. The Administrator verified the work on 11-26-2024. b On 11-26-2024 the Maintenance Supervisor/designee replaced the battery operated smoke alarms that had manufactured dates of 2013 with new battery operated smoke alarms to meet set standards. The Administrator verified the work on 11-26-2024. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 11-27-2024 the Administrator in serviced the Maintenance Supervisor/designee	12/06/2024

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	and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure at least 3 of 50 resident room battery operated smoke alarms were maintained. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect at least 6 or more residents, staff and visitors. Findings include: Based on observations of eight resident room battery powered smoke alarms during record review on 11/14/24 between 10:00 a.m. and 2:15 p.m. with the Maintenance Director present, manufacturer's documentation affixed to the battery operated smoke alarms had manufactured dates of 2013 for 3 of 8 smoke alarms. Based on interview at the time of observations of the smoke alarms during record review, the Maintenance Director confirmed the manufactured dates of 3 of 8 smoke alarms to be 2013. He further said there were several other smoke alarms of the same style in other resident rooms, and he was in the process of replacing them. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		on the requirement to ensure all battery operated smoke alarms are maintained and tested monthly to meet set standards. b Maintenance Supervisor/designee will ensure all battery-operated smoke alarms are maintained and tested monthly and will document the results on the Battery-Operated Smoke Detector Maintenance Log to be filed in the Life Safety Binder as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction	

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			developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.** **Our date of compliance is 12-6-2024.**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on record review and interview, the facility failed to ensure there was documentation available to show 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned,	K 0324	**K324**– It is the intent of the facility to ensure there was documentation available to show kitchen exhaust systems are inspected semiannually to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 10-8—2024 the facilities fire suppression company completed the semiannual inspection on the range hood exhaust system and documented both the semiannual inspection results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work on 10-9-2024 . **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator in serviced	12/06/2024

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	it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect kitchen staff and residents, staff, and visitors while in the main dining room. Findings include: Based on record review on 11/14/24 between 10:00 a.m. and 2:15 p.m. with the Maintenance Director present, there were no semiannual inspection reports available during the past twelve months for the range hood exhaust system. Based on interview at the time of record review, the Maintenance Director said the range hood has been inspected by the vendor twice during the past 12 month period but was unable to locate the inspection documentation. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		the Maintenance Supervisor/Dietary Manager to ensure the semiannual inspection is conducted on the range hood exhaust system and documented to meet set standards. b. The Maintenance Supervisor and Dietary Manager will ensure the semiannual inspection is conducted on the range hood exhaust system and documented as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The monitoring results will be presented by the Administrator at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure	

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(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
			compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12-6-2024.**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections fully in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 52 of the past 52 weeks for the sprinkler system's pressure gauges. 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 in the facility. Findings include: Based on record review on 11/14/24 between 10:00 a.m. and 2:15 p.m. with the Maintenance Director present, there was documentation available to	K 0353	**K353** – It is the intent of the facility to ensure to document sprinkler system inspections fully in accordance with NFPA 25 for dry sprinkler system for 52 weeks for the sprinkler system's pressure gauges and to ensure fire department connection is in accordance with NFPA 25, 2011 edition, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems and to ensure the ceiling in sprinklered smoke compartments is maintained to allow sprinkler heads to function to their full capability to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 11-25-2024 through 11-29-2024 the Maintenance Supervisor conducted the weekly inspection of the dry sprinkler system gauges on all 4 sprinkler gauges and the documentation was put into the Life Safety Binder to meet set standards. The Administrator verified the work on	12/06/2024

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	155275	A. BUILDING 01 B. WING	11/14/2024

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	show the facility's dry sprinkler system gauges were inspected weekly during all 52 weeks of the past 12 month period, however, only 2 of the 4 sprinkler gauges were documented as being inspected each week. Based on interview at the time of record review, the Maintenance Director confirmed there only 2 of the 4 sprinkler gauges documented as being inspected during the past 52 week period. Based on observations between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director the facility had four pressure gauges at the sprinkler riser. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 fire department connection was in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all occupants.		11-29-2024. 2. The Maintenance Supervisor installed FDC signage at the Southeast side of the facility and replaced the missing cap to meet set standards. The Administrator verified the work on 12-4-2024. 3.On 12-5-2024 the Maintenance Supervisor sealed the gap around a pendent sprinkler head within the West hall furnace room/closet with a one hour fire rated material to meet set standards. The Administrator verified the work on 12-5-2024 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 11-27-2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure weekly inspections of the dry sprinkler system gauges are done on all 4 sprinkler gauges, to ensure FDC sign is present and all caps are there and to ensure all gaps are sealed to meet set standards. 2.Maintenance Supervisor/designee will ensure weekly inspections of the dry sprinkler system gauges are done on all 4 sprinkler gauges, to ensure FDC sign is present and all	

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	Findings include: Based on observations on 11/14/24 between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, the facility's fire department connection (FDC) was located on the southeast side of the facility. There was no FDC signage provided at the fire department connection for the responding fire department to lead them to the FDC for easy identification. Furthermore, one of two caps was missing from the fire department connection. Based on interview at the time of observation, both issues were acknowledged by the Maintenance Director who agreed there should be FDC signage at the FDC and the missing cap replaced. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure the ceiling in 1 of 7 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect at least 10 residents, staff, and visitors. Findings include: Based on observations on 11/14/24 between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, there was an 8 inch by 8 inch gap around a pendent sprinkler head within the West Hall furnace room/closet that was not properly fire stopped. Based on interview at the time of observation, the Maintenance Director		caps are there and to ensure all gaps are sealed as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12-6-2024.**	

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	acknowledged the 8 inch by 8 inch gap penetrating the ceiling and around the pendent sprinkler head in the West Hall furnace room/closet that was not properly fire stopped. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure electrical wiring was protected in 1 of 7 smoke compartments. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect mostly staff while in the Employee Breakroom. Findings include: Based on observations on 11/14/24 between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, there was a wall mounted electrical receptacle in the Employee Breakroom that was hanging from the wall and exposing wires. Based on interview at the time of observation, the Maintenance Director acknowledged the hanging electrical receptacle in the Employee Breakroom and said he would fix it as soon as possible.	K 0511	**K511**– It is the intent of the facility to ensure electrical wiring is protected in all smoke compartments to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 12-2-2024 the Maintenance **K511**– It is the intent of the facility to ensure electrical wiring is protected in all smoke compartments to Supervisor/designee repaired the wall mounted electrical receptacle in the employee breakroom that was hanging from the wall and exposing wires to meet set standards. The Administrator verified the work on 12-2-2024_ . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT**	12/06/2024

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**REOCCURRENCE**: a On 11-27-2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure electrical wiring is protected in all smoke compartments to meet set standards. b Maintenance Supervisor/designee will ensure electrical wiring is protected in all smoke compartments as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with	

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			subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12-6-2024.**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills 1. Based on record review and interview, the facility failed to ensure 9 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 11/14/24 between 10:00 a.m. and 2:15 p.m. with the Maintenance Director present, the following fire drill reports were listed as silent fire drills and were not provided with documentation for the transmission of the alarm to the monitoring company: a. 11/29/23 (No time listed) on second shift b. 12/27/23 @ 5:30 a.m. on the third shift c. 02/15/24 @ 2:15 p.m. on the second shift d. 03/26/24 @ 5:30 a.m. on the third shift e. 05/28/24 @ 2:45 p.m. on the second shift f. 06/26/24 @ 5:15 p.m. on the third shift	K 0712	**K712** –It is the intent of the facility to ensure fire drill reports include complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months and to ensure fire drills are held at varied times for 3 of 3 employee shifts during 4 of 4 quarters to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10-7-2024 at 9:45, 11-27-2024 at 2:45 and 12-5-2024 at 10:30 the Maintenance Supervisor conducted fire drills (live and silent) on each shift and verified transmission of the alarm received by the monitoring company and documented the information in the facilities life safety binder to meet set standards. On 12-5-2024 the Administrator confirmed the drills. b On 12-5-2024 the Maintenance Supervisor will	12/06/2024

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	g. 07/31/24 @ 9:45 a.m. on the first shift h. 08/29/24 @ 2:45 p.m. on the second shift i. 09/30/24 @ 5:30 a.m. on the third shift Based on interview at the time of record review, the Maintenance Director confirmed 9 of the 12 fire drills conducted during the past 12 month period were silent fire drills and further confirmed there was no information on those fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3-1.19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 11/14/24 between 10:00 a.m. and 2:15 p.m. with the Maintenance Director present, the following was noted: a. 3 of 4 first shift (day) fire drills were performed between 9:45 a.m. and 10:30 a.m. b. 3 of 4 second shift (evening) fire drills were performed between 2:15 p.m. and 2:45 p.m. (the fourth fire drill during the second shift was not provided with a time) c. 3 of 4 third shift (night) fire drills were performed at 5:30 a.m. (the fourth fire drill listed as a third shift fire drill was performed at 5:15 p.m. which was not a third shift time).		schedule fire drills (live and silent) on each shift, each quarter, in varying conditions to meet set standards. On 12-5-2024 the Administrator confirmed the scheduled drills. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 11-27-2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure to verify the transmission of the alarm is received by the monitoring company and to ensure fire drills (live and silent) are conducted quarterly, on each shift, under varying conditions to meet set standards. b Maintenance Supervisor/designee will ensure to verify the transmission of the alarm is received by the monitoring company and will ensure fire drills (live and silent) are conducted quarterly, on each shift, under varying conditions as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review	

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	Based on interview at the time of record review, the Maintenance Director acknowledged the times of the first, second, and third shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The fire drill documentation will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12-6-2024.**	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with	K 0761	**K761** – It is the intent of the facility to ensure an annual inspection and testing of oxygen room fire door assembly is	12/06/2024

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	LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf		completed in accordance with LSC 19.1.1.4.1.1 to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 11-27-2024 the Maintenance Supervisor conducted the annual inspection of the oxygen transfilling room fire door assembly and documented the results in the Life Safety Binder to meet set standards. The Administrator verified the work on 11-27-2024 . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 11-27-2024 the Administrator in serviced the maintenance Supervisor to ensure an annual inspection and testing of oxygen room fire door assembly is completed and documented to meet set standards. b Maintenance Supervisor/designee will ensure an annual inspection and testing of oxygen room fire door assembly is completed and documented as a part of the facility's annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance	

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	closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect at least 20 residents, as well as staff, and visitors. Findings include: Based on record review on 11/14/24 between 10:00 a.m. and 2:15 p.m. with the Maintenance Director present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly for the past 12 month period. The most recent oxygen transfilling room for door assembly inspection was dated 09/06/23. Based on interview at the time of record review, the Maintenance Director said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly available to review for the past 12 month period. Based on observations during a tour of the facility between 2:15 p.m. and 4:30 p.m., there was one oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12-6-2024.**	
K 0914 SS=F	NFPA 101 Electrical Systems - Maintenance and			

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Bldg. 01	Testing Based on observation, record review and interview; the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review on 11/14/24 between 10:00 a.m. and 2:15 p.m. with the Maintenance Director present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles for the past 12 month period. The most recent resident room receptacle test was dated 07/24/23. Based on interview at the time of record review, the Maintenance Director said electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew with a few exceptions from when a receptacle had to be replaced. The Maintenance Director said he could not find documentation to show that annual	K 0914	**K914**– It is the intent of the facility to ensure complete documentation is available for all non hospital grade electrical receptacles in all resident room locations testing at least annually to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 11-21-2024 the Maintenance Supervisor completed the annual resident room receptacle testing for non hospital grade receptacles and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work on 11-21-2024. 2 **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 11-27-2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement the annual electrical receptacle testing must be completed annually and documented in the life safety binder to meet set standards. b Maintenance Supervisor/designee will ensure the annual electrical receptacle testing is completed and documented as a part of the	12/06/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155275	A. BUILDING 01 B. WING	11/14/2024

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

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	testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period. Based on observations between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Maintenance Director, there were at least four to six electrical receptacles in each resident room. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12-6-2024.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155275	A. BUILDING 01 B. WING	11/14/2024

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WATERS OF PRINCETON, THE	1020 W VINE ST PRINCETON, IN 47670

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K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to ensure a passing annual fuel quality test was performed for 1 of 1 diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 11/14/24 between 10:00 a.m. and 2:15 p.m. with the Maintenance Director present, there was a documented annual fuel quality test for the diesel generator available for review, which was dated 9/30/24. The comments section of the report stated "SUGGEST investigating source of CONTAMINATION. WATER and/or SEDIMENT exceeds ASTM specification and can cause corrosion, fuel system component wear, reduce filter life and promote microbiological growth. Water exceeds ASTM specifications. SUGGEST investigating the source of CONTAMINATION. Water can cause SMOKING, fuel system component WEAR and CORROSION, reduce FILTER LIFE and promote MICROBIOLOGICAL GROWTH." Based on interview at the time of record review, the Maintenance Director said another diesel fuel	K 0918	**K918** – It is the intent of the facility to ensure a passing annual fuel quality test is performed for diesel powered generator to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: a. On 9-30-2024 the facilities generator contractor removed all the current fuel and cleaned the tank and refilled the tank with new fuel. Also the new fuel was retested and it passed and the documentation is in the Life Safety Binder to meet set standards. The Administrator verified the work on 9-30-2024. 1 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 2 **MEASURES TO PREVENT REOCCURRENCE**: a On 11-27-2024 The Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure a passing annual fuel quality test is performed for the diesel-powered generator to meet set standards. b The Maintenance Supervisor/designee will ensure a passing annual fuel quality test is performed for the diesel-powered generator as a part of the facility's annual Preventive Maintenance	12/06/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155275	A. BUILDING 01 B. WING	11/14/2024

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

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	sample was taken on 11/08/24 after the old fuel was removed and replaced, but the facility has not yet received the most recent fuel sample results. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 3 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12-6-2024.**	