STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	A. BUILDING	
		155275	B. WING		11/14/2024
			<u> </u>	-	
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD	
				V VINE ST	
WATERS	S OF PRINCETON,	THE	PRINC	ETON, IN 47670	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROUDERIG BY AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
E 0000					
Bldg					
9-	An Emergency Pre	paredness Survey was	E 0000	We are requesting a desk rev	iew
		ndiana Department of Health in	L 0000	vve are requesting a desk rev	icvv.
	accordance with 42	-			
	accordance with 42	. CI K 403.73.			
	Survey Date: 11/14	1/24			
	Survey Date. 11/1-	7/27			
	Facility Number: (	000175			
	Provider Number:				
	AIM Number: 100				
	7 mvi rvamoci. 100	2/1110			
	At this Emergency	Preparedness survey, The			
		n was found not in compliance			
		reparedness Requirements for			
		icaid Participating Providers			
	and Suppliers, 42 C				
	and Suppliers, 42 C	FK 463.73			
	The facility has a c	apacity of 95 certified beds and			
	I	at the time of this visit.			
	liad a celisus of oo	at the time of this visit.			
	Quality Review con	mpleted on 11/22/24			
	Quality Review col	mpieted on 11/22/24			
	The requirement at	42 CFR, Subpart 483.73 is NOT			
	MET as evidenced	-			
	WILT as evidenced	oy.			
E 0041	482 15(e) 483 73	8(e), 485.542(e), 485.62			
SS=F		LTC Emergency Power			
Bldg	l 100pital 0/ till alle	2 2 1 3 2 morganity 1 awar			
2.49.	Based on record rev	view and interview, the facility	E 0041	<b>E041</b> – It is the intent of the fac	cility 12/06/2024
		t the emergency power system	E 0041	to ensure a passing annual fu	•
	•	and maintenance requirements		quality test is performed for th	
		Care Facilities Code, NFPA		diesel powered generator to n	
		y Code in accordance with 42			ICCL
	CFR 483.73(e)(2).	y Code III accordance with 42		set standards.  1. CORRECTIVE ACTIONS	
	CFR 403./3(c)(2).				
	Raced on record ro	view and interview, the facility		TAKEN: a. On 9-30-2024 the facilities	_
		assing annual fuel quality test			
	_			generator contractor removed	
	was performed for	1 of 1 diesel powered generator.		the current fuel and cleaned the	ie
I ADOD: TO	W DIDECTORIC OR TO	AMDED (CLIDDI IED DEDD ECT)	ICNATURE	TOTAL S	OLO B : TO
LABUKATUK	CI DIKECTOK'S OK PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATUKE	TITLE	(X6) DATE
andrew gri	ubb		rdo		12/09/2024

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays 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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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	TIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	<u></u>	COMPL	ETED
		155275	B. W	ING		11/14/2024	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	2			VINE ST		
\A/ATEDG		TUE			ETON, IN 47670		
WATERS	S OF PRINCETON,	INE		PRINCE	ETON, IN 47670		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	NFPA 99, Health C	are Facilities Code, 2012 Edition			tank and refilled the tank with	new	
	Section 6.5.4.1.1.2	states Type 2 EES (Essential			fuel. Also the new fuel was		
	Electrical System) g	generator sets shall be			retested and it passed and the	:	
	inspected and tested	l in accordance with Section			documentation is in the Life Sa	afety	
	6.4.4.1.1.3. Section	6.4.4.1.1.3 states maintenance			Binder to meet set standards.		
	shall be performed	in accordance with NFPA 110,			The Administrator verified the	work	
	Standard for Emerg	ency and Standby Power			on 9-30-2024 . <b>ALL OTHERS</b>		
	Systems, 2010 Edit	ion, Chapter 8. NFPA 110,			WITH POTENTIAL TO BE		
	Section 8.3.8 states	a fuel quality test shall be			AFFECTED:		
	performed at least a	nnually using tests approved			a All residents and all staff		
	by ASTM standards	s. This deficient practice			and visitors have the potential	to	
	could affect all resid	dents, as well as staff and			be affected but none were.		
	visitors.				2 MEASURES TO PREVE	NT	
					REOCCURRENCE:		
	Findings include:				a On 1-27-2024 The		
					Administrator in serviced the		
	Based on record rev	view on 11/14/24 between 10:00			Maintenance Supervisor/designee		
	a.m. and 2:15 p.m.	with the Maintenance Director			on the requirement to ensure a		
	present, there was a	documented annual fuel		passing annual fuel quality test is			
	quality test for the o	liesel generator available for			performed for the diesel-powe	red	
	review, which was	dated 9/30/24. The comments			generator to meet set standard	ds.	
	section of the repor	t stated "SUGGEST			b The Maintenance		
	investigating source	e of CONTAMINATION.			Supervisor/designee will ensu	re a	
	WATER and/or SE	DIMENT exceeds ASTM			passing annual fuel quality test is		
	specification and ca	in cause corrosion, fuel system			performed for the diesel-powe	red	
	component wear, re	duce filter life and promote			generator as a part of the facil	ity's	
		wth. Water exceeds ASTM			annual Preventive Maintenand	e	
	specifications. SUC	GGEST investigating the			Program and document those		
	source of CONTAN	MINATION. Water can cause			inspection results as appropria	ate.	
	SMOKING, fuel sy	stem component WEAR and			If any issues are discovered, t	hey	
	CORROSION, redu	ice FILTER LIFE and promote			will be addressed and resolve	d	
	MICROBIOLOGIC	CAL GROWTH." Based on			immediately. The Maintenanc	е	
	interview at the tim	e of record review, the			Supervisor/designee will revie	w	
		or said another diesel fuel			with the Administrator the		
	sample was taken o	n 11/08/24 after the old fuel			inspection results.		
	was removed and re	eplaced, but the facility has not			c The Administrator will		
	yet received the mo	st recent fuel sample results.			monitor adherence to the		
					Emergency Preparedness Pol	icy	
	This finding was re	viewed with the Administrator			Manual and validate the		
		irector during the exit			documentation is in place.		

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HNA821 Facility ID: 000175

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

PRINTED: 12/11/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/14/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	conference.			a At least every month the load bank testing will be completed, and weekly inspect of the generator will be conducted to ensure compliance; the Administrator and Maintenance Supervisor/designee will reviee Emergency Preparedness Pom Manual and make changes as necessary to meet set standated Those reviews will be documented as appropriate. The Administr will present the training result the Quality Assurance/Performance Improvement (Comeeting. Results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a 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.	etion cted  ce ew the licy s rds. ented ator s at  AA/PI)  by  n as		
K 0000							
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000	We are requesting a desk rev	iew.		

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Event ID:

HNA821 Facility ID: 000175

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/14/2024
	ROVIDER OR SUPPLIER		1020 W	ADDRESS, CITY, STATE, ZIP COD V VINE ST ETON, IN 47670	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION  1/24	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Facility Number: 0 Provider Number: AIM Number: 1002	00175 155275			
	Princeton was found Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L	Code survey, The Waters of d not in compliance with articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, .SC), Chapter 19, Existing ancies and 410 IAC 16.2.			
	Type V (000) constructions sprinklered. The far with hard wired sme and spaces open to operated smoke alar	ity was determined to be of ruction and was fully cility has a fire alarm system oke detectors in the corridors the corridors, plus battery rms in all resident sleeping has a capacity of 95 and had a time of this survey.			
	were sprinklered an services were sprink	idents have customary access d all areas providing facility klered, except one detached detached metal pod, both facility storage.			
	Quality Review con	npleted on 11/22/24			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lightir	ng			
-	interview; the facili documentation was of 7 battery powered	view, observation, and ty failed to ensure provided for the testing of 7 d emergency light units that y for 30 seconds during 3 of	K 0291	K291 – It is the intent of the facility to ensure documentation provided for the testing of the battery powered emergency li units that are tested monthly f	ght

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HNA821

Facility ID: 000175

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  11/14/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	during the past 12 n would provide light outages. LSC 19.2. shall be provided in Section 7.9.3.1.1 (1 shall be conducted n weeks and a maxim for not less than 30 testing shall be conducted of 1 1/2 hours if the battery powered and inspections and test for inspection by the jurisdiction. This d	and annually for 90 minutes nonths to ensure the light ing during periods of power 9.1 requires emergency lighting accordance with Section 7.9. requires functional testing monthly, with a minimum of 3 um of 5 weeks between tests, seconds, (3) Functional ducted annually for a minimum emergency lighting system is 4 (5) Written records of visual s shall be kept by the owner e authority having efficient practice could affect all staff and visitors in the		30 seconds and annually for 9 minutes to ensure the light wo provide lighting during periods power outages to meet set standards.  1.CORRECTIVE ACTIONS TAKEN:  1.On 11-30-2024 the Maintenance Supervisor/design conducted the monthly 30 sect testing and the 90 minute annual testing of the battery powered emergency lights and document the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work on 11-30-20.	gnee cond ual ented	
	a.m. and 2:15 p.m. v present, the facility' report indicated the light units were test however, there were during December 20 of 2024. Furthermodocumentation avai powered emergency annually for 90 min period. Based on olbetween 2:15 p.m. at the facility with the were 7 battery power observed. Based on record review, the Market were no month during December 20.	riew on 11/14/24 between 10:00 with the Maintenance Director is preventative maintenance 7 battery powered emergency ed monthly for 30 seconds, eno 30 second tests performed 023, and January and February ore, there was no lable to show the battery or light units were tested utes during the past 12 month poservations on 11/14/24 and 4:30 p.m. during a tour of Maintenance Director, there existed emergency light units an interview at the time of Maintenance Director stated only 30 second tests performed 023, and January and February minute test performed during		2.ALL OTHERS WITH POTENTIAL TO BE AFFECT  1.All residents and all sta and visitors have the potentia be affected but none were.  3.MEASURES TO PREVEN REOCCURRENCE:  1.On 11-27-2024the Administrator in serviced the Maintenance Supervisor/desig on the requirement to ensure provide and maintain battery powered emergency lights including conducting the mon 30 second testing and the 90 minute annual testing and document the results in the Li Safety Binder to meet set standards.  2.Maintenance Supervisor/designee will ensu- provide and maintain battery	aff I to  T  gnee to  thly	

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

PRINTED: 12/11/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/14/2024	
	PROVIDER OR SUPPLIER		1020 V	ADDRESS, CITY, STATE, ZIP COD V VINE ST ETON, IN 47670		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		
	(EACH DEFICIEN REGULATORY OF the past 12 month p emergency light un.	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION eriod on the 7 battery powered		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	thly  fe  meet are essed ne gnee ator  TIVE  will ance  chly ce  d. hly ce  d	
				compliance is maintained.		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155275	B. WI	NG	<del>_</del>	11/14/2024	
				-			
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD		
I WATER	OF PRIMOFTON	TUE			V VINE ST		
WATERS	S OF PRINCETON	, IHE		PRINC	ETON, IN 47670		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		ATE	COMPLETION
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					This plan of correction		
					constitutes our credible		
					allegation of compliance wit	h	
					all regulatory requirements.		
					Our date of compliance is		
					12-6-2024.		
K 0293	NFPA 101						
SS=E	Exit Signage						
Bldg. 01							
		ion and interview, the facility	K 02	293	<b>K293</b> – It is the intent of the fa	cility	12/06/2024
		of 1 door to a courtyard could			to ensure door to a courtyard		
		a facility exit. LSC 7.10.8.3.1			could not be mistaken as a fa	cility	
		ssage, or stairway that is			exit to meet set standards.	_	
		a way of exit access and that is			1 CORRECTIVE ACTIONS	s	
	_	d so that it is likely to be			TAKEN:		
		it shall be identified by a sign			a On 11-19-2024 the		
		ws: NO EXIT. The NO EXIT			Maintenance Supervisor/designatella de "Na Fait" a impagnation	-	
	_	word NO in letters 2 inches			installed a "No Exit" sign on th		
	_	width of 3/8 inch, and the word ord NO, unless such sign is an			Memory Care Unit's outside d	loor	
		sign. This deficient practice			to the courtyard to meet set standards. The Administrator		
		nts in the Memory Care Unit.			verified the work on		
	could affect reside	nts in the Memory Care Onit.			11-19-2024		
	Findings include:				2 ALL OTHERS WITH		
	i mangs merace.				POTENTIAL TO BE AFFECT	ED.	
	Based on observat	ions on 11/14/24 between 2:15			a All residents and all staf	1	
		during a tour of the facility with			and visitors have the potential		
	1 ^ ^	Director, the Memory Care Unit's			be affected but none were.		
		courtyard was not posted with			3 MEASURES TO PREVE	NT	
		Based on interview at the time of			REOCCURRENCE:		
	_	e Maintenance Director said			a On 11-27-2024 the		
	•	a required exit and agreed there			Administrator in serviced the		
		EXIT" sign on the door.			Maintenance Supervisor/design	<sub>anee</sub>	
		5			on the requirement to ensure		
	This finding was r	eviewed with the Administrator			doors are marked accordingly	and	
		Director during the exit			not mistaken as a facility exit		
	conference.				meet set standards.		
					b Maintenance		
	3.1-19(b)				Supervisor/designee will ensu	ıre	

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

PRINTED: 12/11/2024 FORM APPROVED OMB NO. 0938-039

	FOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MUI A. BUII B. WIN	LDING	nstruction 01	COME	E SURVEY LETED 4/2024
	OF PRINCETON,			1020 W	DDRESS, CITY, STATE, ZIP COD VINE ST ETON, IN 47670		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE DPRIATE	(X5) COMPLETION DATE
					doors are marked accordinated mot mistaken as a facility of part of the facility's month. Preventive Maintenance Program. If any issues and discovered, they will be adand resolved immediately. Maintenance Supervisor/d will review with the Adminithe inspection results.  c The Administrator with monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4 MONITORING CORRECTIVE ACTION:  a The inspection result be presented by the Maintenance documentation result be presented by the Maintenance documentation is in place.  4 MONITORING CORRECTIVE ACTION:  a The inspection result be presented by the Maintenance documentation will present the presented by the Maintenance of the Administrator will present the presented by the Maintenance of the Administrator will present the presented by the Maintenance of the Mai	xit as a y e dressed The esignee strator I s will enance the he onthly nance ting. em ed by ction ed as ure with ts.	

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Event ID:

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Facility ID: 000175

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	r í	JILDING	ONSTRUCTION  01	(X3) DATE COMPL 11/14	ETED
	PROVIDER OR SUPPLIER			1020 W	ADDRESS, CITY, STATE, ZIP COD / VINE ST ETON, IN 47670		
	ı						ars)
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL				TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCT		DATE
K 0300	NFPA 101						
	Protection - Other						
SS=F Bldg. 01	interview; the facilit documentation for to of all battery operat rooms was available 101 in 4.6.12.3 state obvious to the publishall be maintained and Signaling Code Maintenance and To equipment shall be accordance with the instructions and per 14. NFPA 72, 14.2 maintenance progra requirements of this equipment manufactor This deficient practistaff, and visitors.  Findings include:  Based on record revalum, and 2:15 p.m. operative mainter room battery power on a monthly basis, performed during Jatthis was confirmed at the time of record facility with the Ma 2:15 p.m. and 4:30 p.m. a	review, observation, and ty failed to ensure he preventative maintenance ed smoke alarms in resident e for 2 of 12 months. NFPA es existing life safety features c, if not required by the Code, NFPA 72, National Fire Alarm, 2010 Edition, 29.10 ests states fire-warning maintained and tested in emanufacturer's published the requirements of Chapter 1.1.1 Inspection, testing, and	K 0	300	K300— It is the intent of the facto ensure documentation for the preventative maintenance of battery operated smoke alarms resident rooms is available an ensure resident room battery operated smoke alarms are maintained to meet set standad 1 CORRECTIVE ACTIONS TAKEN:  a On the Maintenance Supervisor/designee performs monthly testing of the resident room battery operated smoke alarms in all resident rooms to meet set standards. The Administrator verified the work 11-26-2024.  b On 11-26-2024 the Maintenance Supervisor/designeplaced the battery operated smoke alarms that had manufactured dates of 2013 who new battery operated smoke alarms to meet set standards. The Administrator verified the on 11-26-2024.  2 ALL OTHERS WITH POTENTIAL TO BE AFFECTION All residents and all staff and visitors have the potential be affected but none were.  3 MEASURES TO PREVEIN REOCCURRENCE:  a On 11-27-2024 the	ed the to congree with work	12/06/2024
	This finding was re	viewed with the Administrator			Administrator in serviced the Maintenance Supervisor/design	gnee	

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Event ID:

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Facility ID: 000175

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155275	B. WI	ING		11/14/2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			/ VINE ST		
WATERS	OF PRINCETON,	THE			ETON, IN 47670		
			1		· · · · · · · · · · · · · · · · · · ·	Т	OV.5
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
IAG		LISC IDENTIFYING INFORMATION irector during the exit	+	TAG		oll oll	DATE
	conference.	irector during the exit			on the requirement to ensure		
	conference.				battery operated smoke alarm		
	3 1 10/b)				are maintained and tested mo	nuniy	
	3.1-19(b)				to meet set standards.		
	2 Rosed on observe	ation and interview, the			b Maintenance	ro oll	
		sure at least 3 of 50 resident			Supervisor/designee will ensu		
					battery-operated smoke alarm		
		red smoke alarms were 72, 2010 Edition, Section			are maintained and tested mo	,	
					and will document the results	UII	
		ss otherwise recommended by bublished instructions, single-			the Battery-Operated Smoke	h	
	-	_			Detector Maintenance Log to		
and multiple-station smoke alarms shall be replaced when they fail to respond to operability				filed in the Life Safety Binder a			
	-				part of the facility's Preventive		
		emain in service longer than 10			Maintenance Program. If any		
	-	of manufacture. This deficient			issues are discovered, they will	ııı be	
	staff and visitors.	t at least 6 or more residents,			addressed and resolved		
	Staff and Visitors.				immediately. The Maintenand		
	Findings include:				Supervisor/designee will revie	vv	
	Findings include:				with the Administrator the		
	Rosed on observed:	ons of aight resident reserv			inspection results.		
		ons of eight resident room oke alarms during record			c The Administrator will		
		between 10:00 a.m. and 2:15			monitor adherence to the		
		tenance Director present,			Preventative Maintenance		
	-	imentation affixed to the			schedule and validate the		
		oke alarms had manufactured			Preventative Maintenance		
		of 8 smoke alarms. Based on			documentation is in place.		
		e of observations of the smoke			4 MONITORING		
		d review, the Maintenance			CORRECTIVE ACTION:	I	
	_	the manufactured dates of 3 of			a The inspection results w		
		be 2013. He further said there			be presented by the Maintena	nce	
					Supervisor/designee to the		
		smoke alarms of the same style oms, and he was in the process			Administrator monthly and the	,	
	of replacing them.	oms, and he was in the process			Administrator will present the inspection results at the month	alv	
	or repracing mem.				1 .	•	
	This finding was ===	viewed with the Administrator			Quality Assurance/Performan		
	_				Improvement (QA/PI) meeting		
		irector during the exit			Inspection results and system		
	conference.				components will be reviewed I	by	
	2.1.10(1)				the QA/PI Committee with		
	3.1-19(b)				subsequent plans of correction	n	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155275	B. WI	NG		11/14/	2024
NAME OF P	PROVIDER OR SUPPLIEF	<b>\</b>			ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF PRINCETON,	THE			VINE ST ETON, IN 47670		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·ΤΕ	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					developed and implemented a 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 rev	view and interview, the facility	K 0.	324	K324– It is the intent of the fac	cility	12/06/2024
	available to show 1 was inspected semi Edition, Standard for Protection of Comm Section 11.4 states be inspected for greetrained, qualified, an acceptable to the autian and in accordance via Schedule for Inspected for Inspection, if the expection, if the expection in the contaminated with expection, and certification in the expection in the expect	re was documentation of 1 kitchen exhaust systems annually. NFPA 96, 2011 or Ventilation Control and Fire mercial Cooking Operations, the entire exhaust system shall case buildup by a properly and certified person(s) atthority having jurisdiction with Table 11.4. Table 11.4, ction for Grease Buildup, rving moderate volume shall be inspected PA 96, 11.6.1 states, upon chaust system is found to be deposits from grease laden mated portions of the exhaust aned by a properly trained, fied person(s) acceptable to the risdiction. Hoods, grease ms, ducts, and other be cleaned to remove minants prior to surfaces ontaminated with grease or he exhaust system is cleaned,			to ensure there was documentation available to sh kitchen exhaust systems are inspected semiannually to me set standards.  1. CORRECTIVE ACTIONS TAKEN:  a. On 10-8—2024 the facilitie fire suppression company completed the semiannual inspection on the range hood exhaust system and documen both the semiannual inspectio results in the facilities Life Saf Binder to meet set standards. The Administrator verified the on 10-9-2024.  2. ALL OTHERS WITH POTENTIAL TO BE AFFECTIA. All residents and all staff at visitors have the potential to be affected but none were.  3. MEASURES TO PREVENT REOCCURRENCE:  a. The Administrator in service.	et es etety work ED: nd	

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Event ID:

HNA821

Facility ID: 000175

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/14/2024	
	PROVIDER OR SUPPLIER		1020 V	ADDRESS, CITY, STATE, ZIP COD V VINE ST CETON, IN 47670		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
	it shall not be coate substance. When as used, a certificate sl servicing company, performing the word cleaning shall be made to the standard residents, staff, dining room.  Findings include:  Based on record revalum, and 2:15 p.m. of present, there were reports available dufor the range hood of interview at the tim Maintenance Direct been inspected by the past 12 month period inspection documer.	d with powder or other n exhaust cleaning service is nowing the name of the the name of the person k, and the date of inspection or aintained on the premises. ice could affect kitchen staff and visitors while in the main  riew on 11/14/24 between 10:00 with the Maintenance Director no semiannual inspection ring the past twelve months exhaust system. Based on the of record review, the or said the range hood has the vendor twice during the did but was unable to locate the		the Maintenance Supervisor/Dietary Manager ensure the semiannual inspet is conducted on the range ho exhaust system and docume to meet set standards. b. The Maintenance Supervis and Dietary Manager will ensure the semiannual inspection is conducted on the range hood exhaust system and docume as a part of the facility's mon Preventive Maintenance Prog and document those inspecti results as appropriate. If an issues are discovered, they waddressed and resolved immediately. The Maintenan Supervisor/designee will revi with the Administrator the inspection results. c. The Administrator will mon adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation place. 4. MONITORING CORRECTI ACTION: a. The monitoring results will presented by the Administrate the monthly Quality Assurance/Performance Improvement (QA/PI) meetin Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correctic developed and implemented	to oction ood onted sor sure of one of the oction ood onted sor sure of one of the oction ook of the oction of the	

PRINTED: 12/11/2024 FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155275 B. WING 11/14/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1020 W VINE ST WATERS OF PRINCETON, THE PRINCETON, IN 47670 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG 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 **NFPA 101** SS=F Sprinkler System - Maintenance and Testing Bldg. 01 1. Based on record review, observation, and K 0353 K353 - It is the intent of the 12/06/2024 interview; the facility failed to document sprinkler facility to ensure to document system inspections fully in accordance with sprinkler system inspections fully NFPA 25 for 1 of 1 dry sprinkler system during 52 in accordance with NFPA 25 for of the past 52 weeks for the sprinkler system's dry sprinkler system for 52 weeks pressure gauges. NFPA 25, Standard for the for the sprinkler system's pressure Inspection, Testing, and Maintenance of gauges and to ensure fire Water-Based Fire Protection Systems, 2011 department connection is in Edition, Section 5.2.4.2 states gauges on dry pipe accordance with NFPA 25, 2011 sprinkler systems shall be inspected weekly to edition, Standard for the ensure that normal air and water pressures are Inspection, Testing and being maintained. Section 5.1.2 states valves and Maintenance of Water Based Fire fire department connections shall be inspected, Protection Systems and to ensure tested, and maintained in accordance with Chapter the ceiling in sprinklered smoke 13. Section 13.1.1.2 states Table 13.1.1.2 shall be compartments is maintained to utilized for inspection, testing and maintenance of allow sprinkler heads to function to valves, valve components and trim. Section 4.3.1 their full capability to meet set states records shall be made for all inspections, standards. tests, and maintenance of the system and its 1.CORRECTIVE ACTIONS components and shall be made available to the TAKEN: authority having jurisdiction upon request. This 1.On 11-25-2024 through deficient practice could affect all residents, staff, 11-29-2024 the Maintenance and visitors in the facility. Supervisor conducted the weekly inspection of the dry sprinkler Findings include: system gauges on all 4 sprinkler gauges and the documentation Based on record review on 11/14/24 between 10:00 was put into the Life Safety Binder

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a.m. and 2:15 p.m. with the Maintenance Director

present, there was documentation available to

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to meet set standards. The

Administrator verified the work on

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155275	B. WI	ING		11/14	/2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			VINE ST		
\//ATEDS	OF PRINCETON,	THE			ETON, IN 47670		
WATERS	OF TAINGETON,	· · · · · · · · · · · · · · · · · · ·		I KING	_ 1 ○ 14, 114 → 1010		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		lry sprinkler system gauges			11-29-2024.		
	-	kly during all 52 weeks of the			2. The Maintenance		
		od, however, only 2 of the 4			Supervisor installed FDC sign	age	
	sprinkler gauges were documented as being				at the Southeast side of the		
	inspected each week. Based on interview at the				facility and replaced the missir	•	
		ew, the Maintenance Director			cap to meet set standards. Th		
		y 2 of the 4 sprinkler gauges			Administrator verified the work	con	
		ig inspected during the past 52			12-4-2024.		
	_	d on observations between 2:15			3.On 12-5-2024 the		
		during a tour of the facility with			Maintenance Supervisor seale		
		rector the facility had four			the gap around a pendent spri		
	pressure gauges at t	he sprinkler riser.			head within the West hall furn		
	TEN : 0" 1"				room/closet with a one hour fir	e	
	-	viewed with the Administrator			rated material to meet set		
		irector during the exit			standards. The Administrator		
	conference.				verified the work on 12-5-2024	<b>ŀ</b> .	
	2.1.10(1)				2.ALL OTHERS WITH		
	3.1-19(b)				POTENTIAL TO BE AFFECTE		
	2 Događan obsami	ention and intermitary tha			1.All residents and all sta		
		ation and interview, the			and visitors have the potential	ιο	
	•	sure 1 of 1 fire department accordance with NFPA 25, 2011			be affected but none were.	-	
		or the Inspection, Testing, and			3.MEASURES TO PREVEN	1	
		ter-Based Fire Protection			REOCCURRENCE: 1.On 11-27-2024 the		
		3.7.1 requires fire department			Administrator in serviced the		
		spected quarterly to verify			Maintenance Supervisor/desig	inee	
	the following:	ispected quarterly to verily			on the requirement to ensure	ji i <del>e e</del>	
		nent connections are visible			weekly inspections of the dry		
	and accessible.	ient connections are visione			sprinkler system gauges are d	one	
		vivels are not damaged and			on all 4 sprinkler gauges, to	0110	
	rotate smoothly.	are not aminipod und			ensure FDC sign is present ar	nd all	
	,	e in place and undamaged.			caps are there and to ensure a		
		lace and in good condition.			gaps are sealed to meet set		
	(5) Identification si	•			standards.		
	(6) The check valve	-			2.Maintenance		
	* *	rain valve is in place and			Supervisor/designee will ensu	re	
	operating properly.	F			weekly inspections of the dry		
		nent connection clapper(s) is in			sprinkler system gauges are d	one	
	place and operating	** * * * * * * * * * * * * * * * * * * *			on all 4 sprinkler gauges, to	OHO	
		ice could affect all occupants.			ensure FDC sign is present ar	nd all	
	I am admorate pract	sia arreer arr cocapario.	1		I susais i po sign is present ai	un	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155275	B. W	ING		11/14/	/2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			VINE ST		
\\\\ATEDS	OF PRINCETON,	THE			ETON, IN 47670		
VVATERS	OF TRINCETON,	1116		I KING	_ 1 O 1 1, 11 1 4 1 0 1 0		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					caps are there and to ensure a		
	Findings include:				gaps are sealed as a part of th		
					facility's Preventive Maintenar		
	Based on observations on 11/14/24 between 2:15				Program and document those		
	p.m. and 4:30 p.m. during a tour of the facility with				inspection results as appropria		
		rector, the facility's fire			If any issues are discovered, t	-	
	-	tion (FDC) was located on the			will be addressed and resolve		
		e facility. There was no FDC			immediately. The Maintenanc		
		the fire department			Supervisor/designee will revie	W	
		responding fire department to			with the Administrator the		
		OC for easy identification.			inspection results.		
		f two caps was missing from			3.The Administrator will		
	•	connection. Based on			monitor adherence to the		
		e of observation, both issues			Preventative Maintenance		
	_	by the Maintenance Director			schedule and validate the		
	-	nould be FDC signage at the			Preventative Maintenance		
	FDC and the missing	ng cap replaced.			documentation is in place.		
					4.MONITORING CORRECTI	VE	
	-	viewed with the Administrator			ACTION:		
		irector during the exit			1.The inspection results v		
	conference.				be presented by the Maintena	nce	
	21104				Supervisor/designee to the		
	3.1-19(b)				Administrator monthly and the		
		and the second			Administrator will present the		
		ration and interview, the			inspection results at the month	-	
	•	sure the ceiling in 1 of 7			Quality Assurance/Performand		
		compartments was maintained			Improvement (QA/PI) meeting		
		eads to function to their full			Inspection results and system		
		ficient practice could affect at			components will be reviewed by	ру	
	least 10 residents, s	tatt, and visitors.			the QA/PI Committee with		
	TO 11 1 1 1 1				subsequent plans of correction		
	Findings include:				developed and implemented a	S	
		11/14/041			deemed necessary to ensure		
		ons on 11/14/24 between 2:15			compliance is maintained.		
	_	during a tour of the facility with			This plan of correction		
		rector, there was an 8 inch by			constitutes our credible		
		pendent sprinkler head within			allegation of compliance with	1	
		ce room/closet that was not			all regulatory requirements.		
		ed. Based on interview at the			Our date of compliance is		
l l	time of observation	the Maintenance Director	1		12-6-2024		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155275	B. W	ING		11/14	/2024
NAME OF P	ROVIDER OR SUPPLIER	•	•		ADDRESS, CITY, STATE, ZIP COD		
					VINE ST		
WATERS	OF PRINCETON,	IHE		PRINC	ETON, IN 47670		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	acknowledged the 8	inch by 8 inch gap					
		e West Hall furnace					
	room/closet that was not properly fire stopped.						
		1L> 2.0kh.m.					
	This finding was re-	viewed with the Administrator					
		irector during the exit					
	conference.						
	3.1-19(b)						
	3.1-17(0)						
K 0511	NFPA 101						
SS=E	Utilities - Gas and	Electric					
Bldg. 01							
		on and interview, the facility	K 0	511	K511- It is the intent of the fac	cility	12/06/2024
		etrical wiring was protected in 1			to ensure electrical wiring is		
	_	tments. NFPA 70, 2011 Edition.			protected in all smoke		
		ptacle Faceplates (Cover eptacle faceplates shall be			compartments to meet set standards.		
		mpletely cover the opening			1 CORRECTIVE ACTIONS	2	
		mounting surface. NFPA 70,			TAKEN:	,	
	_	le 406.5 (F) Exposed Terminals,			a On 12-2-2024 the		
		e enclosed so that live wiring			Maintenance <b>K511</b> – It is the ir	ntent	
	•	posed to contact. This			of the facility to ensure electric		
		ould affect mostly staff while in			wiring is protected in all smoke	е	
	the Employee Break	kroom.			compartments to		
					Supervisor/designee repaired		
	Findings include:				wall mounted electrical recept		
	Rased on observation	ons on 11/14/24 between 2:15			in the employee breakroom th		
		during a tour of the facility with			was hanging from the wall and exposing wires to meet set	1	
		rector, there was a wall			standards. The Administrator		
		receptacle in the Employee			verified the work on 12-2-2024		
		s hanging from the wall and				_	
		sed on interview at the time of			2 ALL OTHERS WITH		
	observation, the Ma				POTENTIAL TO BE AFFECTE	ED:	
		anging electrical receptacle in			a All residents and all staff	f	
		kroom and said he would fix it			and visitors have the potential	to	
	as soon as possible.				be affected but none were.		
			1		3 MEASURES TO PREVE	NT	I

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Event ID:

HNA821 Facility ID: 000175

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

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	ING	01	COMPL	ETED
		155275	B. WING			11/14/	2024
			ST	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			VINE ST		
WATERS	S OF PRINCETON,	THE		PRINCETON, IN 47670			
WATERC	OI TIMINOLION,	1112	<u> </u>	NINOL	1014, 114 47 07 0		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	\G	DEFICIENCY)		DATE
	_	viewed with the Administrator			REOCCURRENCE:		
		Pirector during the exit			a On 11-27-2024 the		
	conference.				Administrator in serviced the		
	21104)				Maintenance Supervisor/design	jnee	
3.1-19(b)				on the requirement to ensure			
			1		electrical wiring is protected in		
					smoke compartments to meet	set	
			1		standards.		
			1		b Maintenance		
					Supervisor/designee will ensu		
					electrical wiring is protected in		
					smoke compartments as a par		
					the facility's monthly Preventiv	'e	
					Maintenance Program and		
					document those inspection res		
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/design		
					will review with the Administra	tor	
					the inspection results.		
					c The Administrator will		
			1		monitor adherence to the		
			1		Preventative Maintenance		
					schedule and validate the		
			1		Preventative Maintenance		
					documentation is in place.		
					4 MONITORING		
			1		CORRECTIVE ACTION:	:11	
			1		a The inspection results w be presented by the Maintena		
					Supervisor/designee to the	i i C <del>C</del>	
			1		Administrator monthly and the		
			1		Administrator will present the		
					inspection results at the month	nlv	
					Quality Assurance/Performance	•	
			1		Improvement (QA/PI) meeting		
			1		Inspection results and system	•	
			1		components will be reviewed I	<b>3</b> V	
					the ΩA/PI Committee with	у	

ENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION (	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155275	B. WING		11/14/2024
WATERS	PROVIDER OR SUPPLIER	THE	1020 V PRINC	ADDRESS, CITY, STATE, ZIP COD V VINE ST ETON, IN 47670	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				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.	5
K 0712 SS=F Bldg. 01	facility failed to ens	review and interview, the sure 9 of 12 fire drill reports documentation of the	K 0712	K712 –It is the intent of the faci to ensure fire drill reports include complete documentation of the	le
	monitoring compan past twelve months drills in health care transmission of the simulation of emerg	re alarm signal to the sy/fire department during the LSC 19.7.1.4 requires fire occupancies shall include the fire alarm signal and gency conditions. This buld affect all residents.		transmission of a fire alarm signate to the monitoring company/fire department during the past twe months and to ensure fire drills held at varied times for 3 of 3 employee shifts during 4 of 4 quarters to meet set standards.  1 CORRECTIVE ACTIONS	lve are
	Findings include:			TAKEN: a On 10-7-2024 at 9:45,	
	on 11/14/24 betwee the Maintenance Di fire drill reports we were not provided v transmission of the company: a. 11/29/23 (No tin b. 12/27/23 @ 5:30 c. 02/15/24 @ 2:15	the facility's fire drill reports on 10:00 a.m. and 2:15 p.m. with director present, the following re listed as silent fire drills and with documentation for the alarm to the monitoring one listed) on second shift a.m. on the third shift a.m. on the second shift a.m. on the third shift a.m. on the third shift		at 10:30 the Maintenance Supervisor conducted fire drills (live and silent) on each shift ar verified transmission of the alar 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 dril	nd rm
	_	p.m. on the second shift		b On 12-5-2024 the	

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f. 06/26/24 @ 5:15 p.m. on the third shift

Event ID:

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Facility ID: 000175

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Maintenance Supervisor will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155275	B. W	NG		11/14/	2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
\A/A TEDC	OF PRIMOFTON	THE			VINE ST		
WATERS	OF PRINCETON,	IHE		PRINCE	ETON, IN 47670		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
	g. 07/31/24 @ 9:45	a.m. on the first shift			schedule fire drills (live and sile	ent)	
	h. 08/29/24 @ 2:45	p.m. on the second shift			on each shift, each quarter, in	,	
	i. 09/30/24 @ 5:30 a.m. on the third shift				varying conditions to meet set		
	Based on interview at the time of record review,				standards. On 12-5-2024 the		
		rector confirmed 9 of the 12			Administrator confirmed the		
	fire drills conducted	during the past 12 month			scheduled drills.		
		ire drills and further confirmed			2 ALL OTHERS WITH		
	_	nation on those fire drill reports			POTENTIAL TO BE AFFECTE	D:	
		nission of the alarm was			a All residents and all staff		
	received by the mor				and visitors have the potential	to	
	Ž				be affected but none were.		
	This finding was re	viewed with the Administrator			3 MEASURES TO PREVE	NT	
	_	irector during the exit			REOCCURRENCE:		
	conference.	S			a On 11-27-2024 the		
					Administrator in serviced the		
	3-1.19(b)				Maintenance Supervisor/desig	nee	
	3.1-51(c)				on the requirement to ensure t		
	,				verify the transmission of the		
	2. Based on record	review and interview, the			alarm is received by the		
		sure fire drills were held at			monitoring company and to en	sure	
	-	f 3 employee shifts during 4 of			fire drills (live and silent) are		
		ficient practice could affect all			conducted quarterly, on each s	shift.	
	residents in the faci	-			under varying conditions to me		
		,			set standards.		
	Findings include:				b Maintenance		
					Supervisor/designee will ensu	re to	
	Based on review of	the facility's fire drill reports			verify the transmission of the		
		n 10:00 a.m. and 2:15 p.m. with			alarm is received by the		
		rector present, the following			monitoring company and will		
	was noted:	-			ensure fire drills (live and silen	t)	
	a. 3 of 4 first shift (	(day) fire drills were performed			are conducted quarterly, on ea	,	
	between 9:45 a.m. a	and 10:30 a.m.			shift, under varying conditions		
	b. 3 of 4 second shi	ift (evening) fire drills were			part of the facility's monthly		
		2:15 p.m. and 2:45 p.m. (the			Preventive Maintenance Progr	am	
	_	ng the second shift was not			and document those inspection		
	provided with a tim	_			results as appropriate. If any		
	_	(night) fire drills were			issues are discovered, they wi	ll be	
		.m. (the fourth fire drill listed as		addressed and resolved			
	_	l was performed at 5:15 p.m.			immediately. The Maintenanc	e	
	which was not a thin	-			Supervisor/designee will review		
	1	•	1		ı ·		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA821 Facility ID: 000175

If continuation sheet Page 19 of 26

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER   155275   B. WING	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  WATERS OF PRINCETON, THE  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  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)  STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670  (X5)  PREFIX  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  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	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G <u>01</u>	COMPLETED
WATERS OF PRINCETON, THE  (X4) ID  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  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.  This finding was reviewed with the Administrator and Maintenance Director during the exit conference.  3.1-19(b) 3.1-51(c)  10  PROVIDER ST PRINCETON, IN 47670  (X5)  (X5)  COMPLETION  DATE  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			155275	B. WING		11/14/2024
WATERS OF PRINCETON, THE  (X4) ID  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  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.  This finding was reviewed with the Administrator and Maintenance Director during the exit conference.  3.1-19(b) 3.1-51(c)  10  PROVIDER ST PRINCETON, IN 47670  (X5)  (X5)  COMPLETION  DATE  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				STRI	EET ADDRESS CITY STATE ZID COD	<u>. I</u>
WATERS OF PRINCETON, THE  PRINCETON, IN 47670  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  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.  This finding was reviewed with the Administrator and Maintenance Director during the exit conference.  3.1-19(b) 3.1-51(c)  PROVIDERS PLAN OF CORRECTION (X5) COMPLETION COMPLETION DATE  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	NAME OF P	ROVIDER OR SUPPLIER	8			
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  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)  (X5) PREFIX TAG  PREFIX TAG THE APPROPRIATE COMPLETION DATE  COMPLETION DATE  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	WATERS	CE DRINCETON	THE			
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  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.  This finding was reviewed with the Administrator and Maintenance Director during the exit conference.  3.1-19(b) 3.1-51(c)  PREFIX TAG  PREFIX TAG  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	WATERS	OF FRINCETON,	IIIE	FINI	NCETON, IN 47070	
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.  This finding was reviewed with the Administrator and Maintenance Director during the exit conference.  The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4 MONITORING  CORRECTIVE ACTION:  3.1-19(b)  3.1-51(c)  TAG  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	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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.  This finding was reviewed with the Administrator and Maintenance Director during the exit conference.  The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4 MONITORING  CORRECTIVE ACTION:  3.1-19(b)  3.1-51(c)  TAG  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	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
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.  This finding was reviewed with the Administrator and Maintenance Director during the exit conference.  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	TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
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)  of the first, second, and third shift fire drills were performed and agreed the times were not varied 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		Based on interview	at the time of record review,		with the Administrator the	
performed and agreed the times were not varied enough.  This finding was reviewed with the Administrator and Maintenance Director during the exit conference.  This finding was reviewed with the Administrator and Maintenance Director during the exit conference.  This finding was reviewed with the Administrator and Maintenance Director during the exit 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 Maintenance Di	rector acknowledged the times		inspection results.	
enough.  Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4 MONITORING CORRECTIVE ACTION:  3.1-19(b)  3.1-51(c)  a The fire drill documentation will be presented by the Maintenance Supervisor/designee to the Administrator monthly and		of the first, second,	and third shift fire drills were		c The Administrator will	
This finding was reviewed with the Administrator and Maintenance Director during the exit conference.  3.1-19(b) 3.1-51(c)  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		performed and agre	ed the times were not varied		monitor adherence to the	
This finding was reviewed with the Administrator and Maintenance Director during the exit conference.  3.1-19(b) 3.1-51(c)  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		enough.			Preventative Maintenance	
and Maintenance Director during the exit conference.  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					schedule and validate the	
conference.  4 MONITORING CORRECTIVE ACTION: a The fire drill documentation will be presented by the Maintenance Supervisor/designee to the Administrator monthly and		This finding was reviewed with the Administrator			Preventative Maintenance	
CORRECTIVE ACTION:  3.1-19(b)  3.1-51(c)  a The fire drill documentation will be presented by the Maintenance Supervisor/designee to the Administrator monthly and		and Maintenance D	irector during the exit		documentation is in place.	
3.1-19(b) 3.1-51(c)  a The fire drill documentation will be presented by the Maintenance Supervisor/designee to the Administrator monthly and		conference.			4 MONITORING	
3.1-51(c)  will be presented by the  Maintenance Supervisor/designee to the Administrator monthly and					CORRECTIVE ACTION:	
Maintenance Supervisor/designee to the Administrator monthly and						ation
to the Administrator monthly and		3.1-51(c)			-	
					• • • • • • • • • • • • • • • • • • •	-
l the Δdministrator will present the					1	
					the Administrator will presen	
inspection results at the monthly					•	-
Quality Assurance/Performance					-	
Improvement (QA/PI) meeting.						-
Inspection results and system					•	
components will be reviewed by						i by
the QA/PI Committee with						
subsequent plans of correction						
developed and implemented as					• · · · · · · · · · · · · · · · · · · ·	l l
deemed necessary to ensure						<del>;</del>
compliance is maintained.					·	
This plan of correction						
constitutes our credible						141.
allegation of compliance with					_	
all regulatory requirements.						•
Our date of compliance is						
12-6-2024.					12-6-2024.	
K 0761 NFPA 101	K 0761	NFPΔ 101				
SS=E Maintenance, Inspection & Testing - Doors		-	pection & Testing - Doors			
Bldg. 01		wantenance, ms	Journal of Tooking - Doors			
Based on observation, record review, and $K 0761$ <b>K761</b> – It is the intent of the $12/06/2024$	٠٠-ق٠٠٠	Based on observation	on, record review, and	K 0761	K761 – It is the intent of the	12/06/2024
interview; the facility failed to ensure an annual facility to ensure an annual				K 0/01		12/00/2024
inspection and testing of 1 oxygen room fire inspection and testing of oxygen			-		1	gen
door assembly was completed in accordance with room fire door assembly is		_				3

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155275	B. W	ING		11/14/	/2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	OF PRIMOFTON	THE			VINE ST		
WATERS	S OF PRINCETON,	THE		PRINCE	ETON, IN 47670		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	·-	DATE
		Communicating openings in			completed in accordance with		
	dividing fire barrier	rs required by 19.1.1.4.1 shall be			LSC 19.1.1.4.1.1 to meet set		
	_	orridors and shall be protected			standards.		
		osing fire door assemblies.			1 CORRECTIVE ACTIONS	3	
	(See also Section 8.3.) LSC 8.3.3.1 Openings				TAKEN:		
	required to have a fire protection rating by Table				a On 11-27-2024 the		
	_	tected by approved, listed,			Maintenance Supervisor		
	_	semblies and fire window			conducted the annual inspecti	on	
		r accompanying hardware,			of the oxygen transfilling room		
		s, closing devices, anchorage,			door assembly and document		
		nce with the requirements of			the results in the Life Safety		
		for Fire Doors and Other			Binder to meet set standards.		
		s, except as otherwise			The Administrator verified the	work	
		de. NFPA 80 5.2.1 states fire			on 11-27-2024 .	WOIN	
	_	all be inspected and tested not			2 ALL OTHERS WITH		
		and a written record of the			POTENTIAL TO BE AFFECTE	ED.	
		signed and kept for inspection			a All residents and all staff		
	_	80, 5.2.4.1 states fire door			and visitors have the potential		
	_	visually inspected from both			be affected but none were.	to	
		overall condition of door			3 MEASURES TO PREVE	NT	
	assembly.	verun condition of door			REOCCURRENCE:	141	
	assemory.				a On 11-27-2024 the		
	NFPA 80 5242 s	tates as a minimum, the			Administrator in serviced the		
	following items sha				maintenance Supervisor to en	cura	
	_	or breaks exist in surfaces of			an annual inspection and testi		
	either the door or fr				of oxygen room fire door asse	-	
		light frames, and glazing beads			is completed and documented	-	
		ely fastened in place, if so			meet set standards.	10	
	equipped.	ery fastened in place, it so			b Maintenance		
		e, hinges, hardware, and			Supervisor/designee will ensu	ro on	
	* *	eshold are secured, aligned,			annual inspection and testing		
		er with no visible signs of					
	_	or with the visible signs of			oxygen room fire door assemb	•	
	damage.	oging or broken			completed and documented a	5 d	
	(4) No parts are mis				part of the facility's annual		
	` '	do not exceed clearances			Preventive Maintenance Progr		
	listed in 4.8.4 and 6				and document those inspectio		
		device is operational; that is,			results as appropriate. If any		
		pletely closes when operated			issues are discovered, they wi	III be	
	from the full open p				addressed and resolved		
	(7) If a coordinator	is installed, the inactive leaf	1		immediately. The Maintenand	e	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNA821 Facility ID: 000175

If continuation sheet Page 21 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155275	B. W	ING		11/14/	/2024
		l .	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	8			VINE ST		
\\\∆T⊏D¢	OF PRINCETON,	THE			ETON, IN 47670		
WATERS	OF TRINCETON,	111L		I KING	_ 1 O 14, 114 47 07 0		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	closes before the ac				Supervisor/designee will revie	W	
		are operates and secures the			with the Administrator the		
	door when it is in the	-			inspection results.		
		vare items that interfere or			c The Administrator will		
		re not installed on the door or			monitor adherence to the		
	frame.				Preventative Maintenance		
	· ′	ications to the door assembly			schedule and validate the		
		have been performed that void the label.			Preventative Maintenance		
	(11) Gasketing and edge seals, where required, are				documentation is in place.		
	inspected to verify their presence and integrity.				4 MONITORING		
	This deficient practice could affect at least 20				CORRECTIVE ACTION:		
	residents, as well as staff, and visitors.				a The inspection results w		
					be presented by the Maintena	nce	
	Findings include:				Supervisor/designee to the		
					Administrator monthly and the	!	
		view on 11/14/24 between 10:00			Administrator will present the		
	_	with the Maintenance Director			inspection results at the month	-	
		was unable to provide			Quality Assurance/Performand		
		an annual inspection of the			Improvement (QA/PI) meeting		
		room fire door assembly for the			Inspection results and system		
		od. The most recent oxygen			components will be reviewed l	by	
		r door assembly inspection			the QA/PI Committee with		
		. Based on interview at the			subsequent plans of correction		
		ew, the Maintenance Director			developed and implemented a	IS	
		ocumentation of an annual			deemed necessary to ensure		
	_	ygen transfilling room fire			compliance is maintained.		
	1	lable to review for the past 12			This plan of correction		
	_	ed on observations during a			constitutes our credible		
		petween 2:15 p.m. and 4:30 p.m.,			allegation of compliance with	n	
		en transfilling room fire door			all regulatory requirements.		
	assembly noted in the	he facility.			Our date of compliance is		
	TE1 : C' 1:	1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			12-6-2024.		
	1	viewed with the Administrator					
		irector during the exit					
	conference.						
	2 1 10/b)						
	3.1-19(b)						
K 0914	NFPA 101						
SS=F		s - Maintenance and					
		, mantonano ana	1				1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY  COMPLETED  11/14/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
Bldg. 01	interview; the facili documentation was nonhospital-grade e resident room locati NFPA 99, Health C Section 6.3.4.1.3 sta hospital-grade, at pa locations where dee anesthesia is administrated in the continuity of the receptacle shall be a The continuity of the electrical receptacle polarity of the hot a each electrical receptacle receptacles) shall be ounces). This deficit residents.  Findings include:  Based on record reviation and 2:15 p.m. suppresent, there was man annual resident resident resident receptacles.  Findings include:	on, record review and try failed to ensure complete available for all lectrical receptacles in all ons tested at least annually. The are Facilities Code 2012 Edition, attes receptacles not listed as attent bed locations and in properties of properties and in properties and in properties and in properties and in properties. Additionally, are properties and in the properties are physical integrity of each confirmed by visual inspection. The grounding circuit in each shall be verified. Correct and neutral connections in obtacle shall be confirmed; and the grounding blade of each (except locking-type and less than 115 grams (4 and the practice could affect all the properties and the maintenance Director of documentation available of coom receptacle test for non obtacles for the past 12 month accent resident room receptacle test for non obtacles for the past 12 month accent resident room receptacle when the Maintenance Director tacles in resident rooms were deceptacles as far as he knew as from when a receptacle had Maintenance Director said he mentation to show that annual	K 0914	K914— It is the intent of the fato ensure complete documer is available for all non hospit grade electrical receptacles is resident room locations testin least annually to meet set standards.  1 CORRECTIVE ACTION TAKEN:  a On 11-21-2024 the Maintenance Supervisor completed the annual reside 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 word 11-21-2024.  2 ALL OTHERS WITH POTENTAL TO BE AFFECT and Visitors have the potential be affected but none were.  3 MEASURES TO PREV REOCCURRENCE:  a On 11-27-2024 the Administrator in serviced the Maintenance Supervisor/desion the requirement the annual electrical receptacle testing in be completed annually and documented in the life safety binder to meet set standards both Maintenance Supervisor/designee will ensithe annual electrical receptacle testing is completed and documented as a part of the docu	ntation al n all n all ng at  IS  IS  III  III  III  III  III  III	

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

PRINTED: 12/11/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  11/14/2024		
	PROVIDER OR SUPPLIER			1020 W	ADDRESS, CITY, STATE, ZIP COD I VINE ST ETON, IN 47670		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		9, Receptacle Testing			facility's Preventive Maintena		
	-	net with all pertinent			Program and document those		
		the past 12 month period.			inspection results as appropri		
	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				If any issues are discovered,	-	
					will be addressed and resolve		
		acles in each resident room.			immediately. The Maintenand		
	six electrical recept	acies in each resident room.			Supervisor/designee will review with the Administrator the	₹W	
	This finding was re	viewed with the Administrator			inspection results.		
		irector during the exit			c The Administrator will		
	conference.	nector during the exit			monitor adherence to the		
	comerciae.				Preventative Maintenance		
	3.1-19(b)				schedule and validate the		
	0.1 17(0)				Preventative Maintenance		
					documentation is in place.		
					4 MONITORING		
					CORRECTIVE ACTION:		
					a The inspection results w	/ill	
					be presented by the Maintena		
					Supervisor/designee to the		
					Administrator monthly and the	•	
					Administrator will present the		
					inspection results at the mont	hly	
					Quality Assurance/Performan	-	
					Improvement (QA/PI) meeting		
					Inspection results and system	-	
					components will be reviewed	by	
					the QA/PI Committee with		
					subsequent plans of correction	n	
					developed and implemented		
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance wit	h	
					all regulatory requirements.		
					Our date of compliance is		
					12-6-2024.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155275	B. W	NG		11/14/	/2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			/ VINE ST		
WATERS	OF PRINCETON,	THE			ETON, IN 47670		
	Г				1		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0918	NFPA 101						
SS=F	Electrical Systems	s - Essential Electric Syste					
Bldg. 01							
	Based on record review and interview, the facility		K 0	918	K918 – It is the intent of the		12/06/2024
	_	assing annual fuel quality test			facility to ensure a passing an		
	_	1 of 1 diesel powered generator.			fuel quality test is performed for		
		are Facilities Code, 2012 Edition			diesel powered generator to n	neet	
		states Type 2 EES (Essential			set standards.		
		generator sets shall be			1.CORRECTIVE ACTIONS		
		d in accordance with Section			TAKEN:		
		6.4.4.1.1.3 states maintenance			a. On 9-30-2024 the facilities		
	_	in accordance with NFPA 110,			generator contractor removed		
	_	ency and Standby Power			the current fuel and cleaned th		
	1 -	ion, Chapter 8. NFPA 110,			tank and refilled the tank with	new	
		a fuel quality test shall be			fuel. Also the new fuel was		
	1 ~	innually using tests approved			retested and it passed and the		
	1 -	s. This deficient practice			documentation is in the Life S	-	
		dents, as well as staff and			Binder to meet set standards.		
	visitors.				The Administrator verified the	work	
	TO 11 1 1 1				on 9-30-2024.		
	Findings include:				1 ALL OTHERS WITH		
		11/14/041			POTENTIAL TO BE AFFECTE		
		view on 11/14/24 between 10:00			a All residents and all staff		
	_	with the Maintenance Director			and visitors have the potential	to	
	1 ~	documented annual fuel			be affected but none were.		
		liesel generator available for			2 MEASURES TO PREVE	NT	
	·	dated 9/30/24. The comments			REOCCURRENCE:		
	section of the report				a On 11-27-2024 The		
		e of CONTAMINATION.			Administrator in serviced the		
		DIMENT exceeds ASTM			Maintenance Supervisor/desig	-	
	_	in cause corrosion, fuel system			on the requirement to ensure		
		educe filter life and promote			passing annual fuel quality tes		
		wth. Water exceeds ASTM			performed for the diesel-powe		
	_	GGEST investigating the			generator to meet set standar	JS.	
		MINATION. Water can cause			b The Maintenance	ro 0	
		stem component WEAR and			Supervisor/designee will ensu		
	· ·	ICA L CROWTH ! Deceder			passing annual fuel quality tes		
		CAL GROWTH." Based on			performed for the diesel-powe		
		e of record review, the			generator as a part of the facil	-	
	Maintenance Direct	for said another diesel fuel	1		annual Preventive Maintenand	ce	I

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

PRINTED: 12/11/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/14/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE			STREET ADDRESS, CITY, STATE, ZIP COD 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 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)			ID PREFIX TAG  PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIAT		(X5) COMPLETION DATE
				a The inspection results we be presented by the Maintenan Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a 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.	hlly ce g. by	

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