

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

PRINTED: 07/07/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155732</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVEROAKS HEALTH CAMPUS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1244 VAIL ST</b> <b>PRINCETON, IN 47670</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code and Environmental Preoccupancy Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a) for the new addition to the 300 Hall. The resident rooms included in the new portion of the 300 Hall include: 313 through 323 with a total of 15 certified beds.</p> <p>Survey Date: 07/05/23</p> <p>Facility Number: 004130 Provider Number: 155732 AIM Number: 200491050</p> <p>At this Life Safety Code and Environmental Preoccupancy survey, the new 300 Hall addition at the Riveroaks Health Campus was found 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 18, New Health Care Occupancies, and with 410 IAC 16.2-3.1-19, Environmental and Physical Standards of Indiana's Health Facilities Rules for Comprehensive care facilities in regard to the Life Safety Code and Environmental Preoccupancy Survey.</p> <p>The new 300 Hall addition is a one story facility and was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 15 certified beds and had a census of 0 at the time of this survey.</p>	K 000			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 07/07/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155732</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVEROAKS HEALTH CAMPUS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1244 VAIL ST</b> <b>PRINCETON, IN 47670</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	Continued From page 1  All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.  Quality Review completed on 07/06/23	K 000			