STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155732	A. BUILDING **02** B. WING _____	**07/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVEROAKS HEALTH CAMPUS	**1244 VAIL ST** **PRINCETON, IN 47670**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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. Survey Date: 07/05/23 Facility Number: 004130 Provider Number: 155732 AIM Number: 200491050 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. 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.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155732	A. BUILDING **02** B. WING _____	**07/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVEROAKS HEALTH CAMPUS	**1244 VAIL ST** **PRINCETON, IN 47670**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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		