Katherine Seibel

PRINTED: 10/13/2023 FORM APPROVED OMB NO. 0938-039

10/12/2023

· · · · · · · · · · · · · · · · · · ·		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/25/2023	
ANDILAN	or correction	155275	B. WING			
	PROVIDER OR SUPPLIER		1020 V	ADDRESS, CITY, STATE, ZIP COD V 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		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000 Bldg						
		5/23 00175 155275	E 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does no constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of	t the	
	At this Emergency Waters of Princetor Emergency Prepare Medicare and Medi and Suppliers, 42 C	Preparedness survey, The a was found in compliance with dness Requirements for caid Participating Providers FR 483.73  Apacity of 95 certified beds and at the time of this visit.		deficiencies. The plan of correction and specific corrective actions are prepa and/or executed in complian with state and federal laws. This plan of correction constitutes a written allegati of substantial compliance w Federal Medicare and Medicaid requirements.	on	
K 0000						
Bldg. 01	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 09/25  Facility Number: 0 Provider Number: AIM Number: 100  At this Life Safety 6	00175 155275	K 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepal and/or executed in compliant	t the set	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE	
P. POWALOK	DIKLETOKS OKTKO		S.MII OILL	IIILL	(AU) DATE	

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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	NT 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 09/25/2023
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD V VINE ST	
WATERS	OF PRINCETON,	THE		ETON, 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
	Life Safety from Fin National Fire Protec Life Safety Code (L	articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the stion Association (NFPA) 101, ,SC), Chapter 19, Existing uncies and 410 IAC 16.2.		with state and federal laws. This plan of correction constitutes a written allegati of substantial compliance wi Federal Medicare and Medicaid requirements.	<b>I</b>
	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 wood shed and one structures used for f				
K 0100 SS=E Bldg. 01	Section 18.1 and that are not address. K-tags, but are de along with the app	nents - Other nents - Other lents - Other le			
	Based on observation failed to ensure 1 of enclosure was free of states all health care constructed, mainta	on and interview, the facility I laundry area dryer room of lint. NFPA 101 at 19.1.1.3.1 c facilities shall be designed, ined and operated to minimize ire emergency requiring the	K 0100	K100 - It is the intent of the factor to ensure laundry area dryer renclosure is free of lint to mees standards.  1 CORRECTIVE ACTIONS TAKEN:	oom et set

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WATERS	S OF PRINCETON, THE	PRINCETON, IN 47670		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	evacuation of occupants. This deficient practice		a On 9-25-2023 and on	
	could affect mostly laundry staff.		10-10-2023 the Maintenance	
			Supervisor/designee cleaned the	
	Findings include:		dryer lint from the floor, wall and	
	!		equipment in the back of the dryer	
	Based on observations on 09/25/23 between 1:15		enclosure within the laundry area	
	p.m. and 4:15 p.m. during a tour of the facility with		to meet set standards. The	
	the Administrator, the floor, wall, and equipment		Administrator verified the work on	
	in the back of the dryer enclosure within the		9-25-2023 and on 10-10-2023.	
	laundry area was substantially covered with dryer		2 ALL OTHERS WITH	
	lint. Based on interview at the time of		POTENTIAL TO BE AFFECTED:	
	observation, the Administrator agreed there was a		a All residents and all staff	
	substantial amount of dryer lint on the floor, wall,		and visitors have the potential to	
	and equipment within the enclosure behind the		be affected but none were.	
	dryers, and further said they would increase the		3 MEASURES TO PREVENT	
	cleaning schedule.		REOCCURRENCE:	
			a On 9-25-2023 the	
	This finding was reviewed with the Administrator		Administrator in serviced the	
	during the exit conference.		Maintenance Supervisor/Laundry	
			Staff/designee on the requirement	
	3.1-19(b)		that laundry area dryer room	
			enclosure must be free of lint to	
			meet set standards.	
	!		b Maintenance	
			Supervisor/Laundry Staff/designee	
	!		will inspect the laundry area dryer	
			room enclosure to ensure it is	
	!		kept free of lint as a part of the	
			facility's weekly 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	
			i reventative maniferiance	

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	OF CORRECTION	IDENTIFICATION NUMBER  155275	A. BUILDING B. WING	01	COMPLETED 09/25/2023	
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	(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	
				schedule and validate the Preventative Maintenance documentation is in place.  4 MONITORING CORRECTIVE ACTION: a The inspection results who be presented by the Maintenan Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performant 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 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 10-20-2023.	nily ce by	
K 0222 SS=E Bldg. 01	be equipped with a requires the use of egress side unless special locking arra CLINICAL NEEDS LOCKING	d means of egress shall not a latch or a lock that f a tool or key from the susing one of the following angements:  OR SECURITY THREAT king arrangements for the				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION  G 01	COM	(X3) DATE SURVEY COMPLETED 09/25/2023			
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE			102	STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX    FACE OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION		
TAG	clinical security no	R LSC IDENTIFYING INFORMATION eeds of the patient are	TAG	G DEFICIENCY)		DATE		
	-	cking device shall be n door and provisions shall						
	-	apid removal of occupants						
		l of locks; keying of all						
		ied by staff at all times; or						
		e means available to the						
	staff at all times.	.2.2.6, 19.2.2.2.5.1,						
	19.2.2.2.6							
	SPECIAL NEEDS	LOCKING						
	ARRANGEMENT	S						
	•	cking arrangements for the						
	1 -	ne patient are used, all of						
		curity Locking requirements						
	1	addition, the locks must be						
		at fail safely so as to						
		s of power to the device; the						
		ted by a supervised er system and the locked						
	•	d by a complete smoke						
		(or is constantly monitored						
	-	cation within the locked						
		the sprinkler and detection						
	,	nged to unlock the doors						
	upon activation.							
		.2.2.5.2, TIA 12-4						
	DELAYED-EGRE							
	ARRANGEMENT							
	* *	delayed-egress locking						
		in accordance with permitted on door						
		ng low and ordinary hazard						
		ngs protected throughout by						
		ervised automatic fire						
		or an approved, supervised						
	automatic sprinkle							
	18.2.2.2.4, 19.2.2							
		ROLLED EGRESS						
	LOCKING ARRAI	NGEMENTS						

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> Co		COMPI	COMPLETED	
155275		B. WING 09/25/2023			/2023		
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	2			/ VINE ST		
\\\\\\	OF DRINGETON	THE					
WATERS	OF PRINCETON,	IHE		PRINCI	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	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Access-Controlled	l Egress Door assemblies					
		lance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2	.2.4					
		BY EXIT ACCESS					
	LOCKING ARRAN						
		t access door locking in					
	-	7.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
		sed automatic sprinkler					
	system.	ээ амэглаг эргингэ					
	18.2.2.2.4, 19.2.2	24					
		on and interview, the facility	K O	222	K222- It is the intent of the fac	cility	10/20/2023
		means of egress through 1 of	I K U	<i>LLL</i>	to ensure the means of egress	•	10/20/2023
		ard gate was readily accessible	through locked exit courtyard gate				
		and visitors. This deficient			is readily accessible for reside	-	
		et at least 13 residents, as well			staff and visitors to meet set	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	-	in The Crossing Unit.	standards.				
	us starr and visitors	in the crossing chin			1 CORRECTIVE ACTIONS	3	
	Findings include:				TAKEN:	•	
	i mamgs meraac.				a On 10-11-2023 the		
	Based on observation	ons on 09/25/23 between 1:15			Maintenance Supervisor/desig	nnee	
		during a tour of the facility with			will repair the courtyard exit ga	•	
		he courtyard exit gate from			from the crossing unit to meet		
	· ·	was equipped with a magnetic			standards. The Administrator		
		four digit code on the adjacent			verified the work on 10-11-202		
	keypad to release.	roar aight code on the adjacent			Verified the Work off 10-11-202	_0	
		entered on the keypad the			2 ALL OTHERS WITH		
		m the magnetic lock, however,			POTENTIAL TO BE AFFECTI	=D·	
	_	It to open because it dropped			a All residents and all staf		
	~				and visitors have the potential		
	down slightly on the magnetic lock side and wedged against the supporting post. To open,				be affected but none were.		
	the gate had to be lifted slightly and pushed open.				3 MEASURES TO PREVE	NT	
		dged by the Administrator at			REOCCURRENCE:		
		tion who indicated the gate			a On 10-9-2023 the		
		en and was unaware the gate			Administrator in serviced the		
	was difficult to ope				Maintenance Supervisor/desig	nnee	
	as annount to ope				on the requirement to ensure	J. 100	
					on the requirement to ensure		İ

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/25/2023	
	PROVIDER OR SUPPLIE S OF PRINCETON,		1020 W	ADDRESS, CITY, STATE, ZIP COD V VINE ST ETON, IN 47670		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		
PREFIX TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION eviewed with the Administrator	PREFIX TAG	means of egress through loc exit courtyard gate is readily accessible for residents, staf visitors to meet set standard b Maintenance Supervisor/designee will ens means of egress through loc exit courtyard gate is readily accessible for residents, staf visitors to meet set standard b Maintenance Supervisor/designee will ens means of egress through loc exit courtyard gate is readily accessible for residents, staf visitors as a part of the facilit monthly Preventive Maintenan Program and document thos inspection results as appropriate any issues are discovered, will be addressed and resolv immediately. The Maintenan Supervisor/designee will reviwith 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 to be presented by the Maintenance documentation results at the monitor adherence to the Administrator will present the inspection results at the monitor adherence to the Administrator will present the inspection results at the monitor adherence to the Administrator will present the inspection results at the monitor adherence to the Administrator will present the inspection results at the monitor adherence will present the inspection results and system of the Administrator will be reviewed the QA/PI Committee with	ked  f and s.  ure ked  f and y's ance e riate. they ed nce iew  will ance ee thly nce eg nthly nce ng. m	
				subsequent plans of correction developed and implemented		

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LPAKIMENT OF HEALTH AND HUR	FORM APPROVED		
ENTERS FOR MEDICARE & MEDIC	AID SERVICES		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 <u>01</u>	COMPLETED
	155275	B. WING	09/25/2023
		·	

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

WATER	S OF PRINCETON, THE	PRINC	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	
			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 10-20-2023.		
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency light set was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all residents, as well as staff and visitors.  Findings include:  Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, one of the two light bulbs in the battery backup light set located at the generator did not illuminate when tested several times. Based on interview at the time of	K 0291	K291 – It is the intent of the facility to ensure battery powered emergency light set is maintained in accordance with LCS 7.9 to meet set standards.  1.CORRECTIVE ACTIONS TAKEN:  1.On 10-11-2023 the Maintenance Supervisor/designee replaced the battery backup light set located on the generator that did not illuminate when tested to meet set standards. The Administrator verified the work on 10-11-2023.  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 10-9-2023 the Administrator in serviced the	10/20/2023	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE S COMPL 09/25/	ETED
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE		1020 V	ADDRESS, CITY, STATE, ZIP COD V VINE ST CETON, 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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
TAG	observation, the Adlight bulbs did not in backup light set at the several times.	ministrator agreed one of two lluminate when the battery he generator was tested viewed with the Administrator	TAG	Maintenance Supervisor/on the requirement to promaintain battery powered emergency light including battery backup light set lot the generator to meet set standards.  2.Maintenance Supervisor/designee will aprovide and maintain batt powered emergency light including the battery back set located on the generator of the facility's Month Preventive Maintenance and document those tests Battery-Operated Emerge Lights and signs Test Log maintain emergency lighting meet set standards. If an issues are discovered, the addressed and resolved immediately. The Maintensues are discovered, the addressed and resolved immediately. The Maintensues are discovered with the Administrator the inspection results.  3.The Administrator the inspection results.  3.The Administrator the inspection results.  4.MONITORING CORRIACTION:  1.The inspection results at the management of the Maintenance of the Preventative Maintenance documentation is in place.  4.MONITORING CORRIACTION:  1.The inspection results at the management of the Maintenance of the presented by the Maintenance of the preventative	designee vide and the cated on ensure to ery ing up light tor as a ly Program s on the ency and will ng to my ey will be mance review will etc.  ECTIVE ults will tenance e d the the	DATE

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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  09/25/2023	
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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) ROULD BE PPROPRIATE COMPLETION DATE	
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extinaccordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door.  Describe the floor hazardous areas to REMARKS.  19.3.2.1, 19.3.5.9	- Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4.		Quality Assurance/Perf Improvement (QA/PI) in Inspection results and a components will be revenue the QA/PI Committee with the QA/PI Committee wit	neeting. system iewed by with orrection ented as ensure ed. n ole nce with nents.	

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i '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	l í	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 09/25/	LETED
	PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	ATE	(X5) COMPLETION DATE
	a. Boiler and Fue b. Laundries (larg c. Repair, Mainter d. Soiled Linen R gallons) e. Trash Collectio (exceeding 64 ga f. Combustible St (over 50 square fo g. Laboratories (if Hazard - see K32 Based on observati failed to ensure 1 o such as a laundry r properly working s deficient practice of the Service Hall co way to the smoking Findings include:  Based on observati p.m. and 4:15 p.m. the Administrator, corridor door was p device, however, th was not attached to the door stayed in t was confirmed by t observation.	er than 100 square feet) nance, and Paint Shops coms (exceeding 64  In Rooms flons) orage Rooms/Spaces eet) or classified as Severe 2) on and interview, the facility of over 10 hazardous area doors, com door, was provided with a elf closing device. This ould affect mostly staff while in rridor as well as resident on the g area.  ons on 09/25/23 between 1:15 during a tour of the facility with the right side laundry room orovided with a self closing the arm of the self closing device the door frame. When tested, the wide open position. This the Administrator at the time of	K 0:		K321– It is the intent of the fato ensure hazardous area dor such as a laundry room door, provided with a properly work self-closing device to meet se standards.  1 CORRECTIVE ACTION TAKEN: a On 10-11-2023 the Maintenance Supervisor/desi will repair the self-closing devand attached the arm to the deframe on the right side laundre room corridor door to meet se standards. The Administrator verify the work on 10-11-2023 to a All residents and all staff and visitors have the potential be affected but none were. 3 MEASURES TO PREVERECCURRENCE: a On 9-25-2023 the Administrator in serviced the Maintenance Supervisor/Laur Staff designee on the required to ensure self-closing devices work properly to meet set	ors, is ing et  S  gnee vice loor y et will 3.  ED: ff I to	10/20/2023

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPL A. BUILDIN B. WING	LE CONSTRUCTION  G  01	(X3) DATE SURVEY COMPLETED 09/25/2023	
	ROVIDER OR SUPPLIE		102	EET ADDRESS, CITY, STATE, ZIP COD 10 W VINE ST NCETON, IN 47670	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFII TAG	CROSS-REFERENCED TO THE APPROP	N (X5) BE COMPLETION DATE
				standards. b Maintenance Supervisor/designee will insall hazardous area doors to the self-closing devices are working properly as a part of facility's monthly Preventive Maintenance Program and document those inspection as appropriate. If any issudiscovered, they will be add and resolved immediately. Maintenance Supervisor/de will review with the Administ 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 be presented by the Maintet Supervisor/designee to the Administrator will present the Administrator will present the inspection results at the moduality Assurance/Performation in the provement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensurcompliance is maintained. This plan of correction constitutes our gradible.	results es are dressed The esignee trator  swill nance the ne nothly ance ing. em ed by tion d as

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       09/25/2023			
	ROVIDER 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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				allegation of compliance with all regulatory requirements. Our date of compliance is 10-20-2023.	
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used cooking in accordance 19.3.2.5.2 * cooking facilities smoke compartments comply who 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer pacton facilities with 30 or fewer pacton facilities in the second	IFPA 96, Standard for and Fire Protection of and Fire Protection of and Operations, unless: and equipment (i.e., small as microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2,  open to the corridor in antist with 30 or fewer in the conditions under 5.3, or in smoke compartments attents comply with 8.3.2.5.4, 19.3.2.5.4. Protected according to 3 are not required to be adous areas, but shall not ridor.  18.3.2.5.4, 19.3.2.5.1	K 0324	K324— It is the intent of the factor to ensure the cook top for stove/oven is shut off at the switch when not in use to meet set standards.  1. CORRECTIVE ACTIONS TAKEN:  a. On 10-10-2023 the Administrator in serviced the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETED			ETED
		155275	B. W	NG	09/25/2023		
		l	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8					
WATERS	OF PRINCETON,	THE	1020 W VINE ST PRINCETON, IN 47670				
WATERS	OF TRINCETON,	111L		FININGETON, IN 47070			
(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		LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
		ining the cooking equipment			Supervisor/designee/Physical		
	_	rom the corridor by partitions			Therapy staff the cooktop		
		3.6.2 through 19.3.6.5.			stove/oven in Physical Therap	•	
		ts of 19.3.2.5.3(1) through (10)			Room must be turned off whe	n not	
	and (13) are met.	A 50 1 25 35 3			in use to meet set standards.		
	· ·	A switch meeting all the			b. On 10-11-2023 the Mainten		
	following is provide				Supervisor/designee installed		
		, or a switch located in a			deactivation switch/lockout tag	gout	
	•	is provided within the cooking			to the stove/oven in Physical		
	1	ates the cooktop or range.			Therapy Room to meet set		
	(b) The switch is used to deactivate the cooktop				standards. The Administrator		
	or range whenever the kitchen is not under staff				verified the work on 10-10-202	23	
	supervision.  This deficient practice could affect up to 5						
	_	-			2. ALL OTHERS WITH	-D.	
		visitors in the Physical			POTENTIAL TO BE AFFECTE		
	Therapy room.				a. All residents and all staff a		
	Findings include:				visitors have the potential to b affected but none were.	е	
	Findings include.				3. MEASURES TO PREVENT		
	Raced on observativ	ons on 09/25/23 between 1:15			REOCCURRENCE:		
		during a tour of the facility with			a.The Maintenance		
	the Administrator, t				Supervisor/designee/Physical		
		cal Therapy Room. The			Therapy staff will ensure the		
		being used at the time of			cooktop stove/oven in Physica	al	
		power to the stove/oven was			Therapy Room is turned off w		
		view at the time of observation,			not in use as a part of the facil		
		onfirmed the cooktop			daily policy and procedures ar	•	
		deactivated when not in use,			document those inspection res		
		Iministrator said she didn't			as appropriate. If any issues		
		eactivation switch for the			discovered, they will be addre		
		cove/oven other than			and resolved immediately. Th		
	unplugging it from				Maintenance Supervisor/Phys		
		•			Therapy staff/designee will rev		
	This finding was re	viewed with the Administrator			with the Administrator the		
	during the exit conf				inspection results.		
					a The Administrator will		
	3.1-19(b)				monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the sys	tems	
					are in compliance.		

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	of correction   IDENTIFICATION NUMBER   A. BUILDING   D1   B. WING		COMPLETED 09/25/2023		
	ROVIDER OR SUPPLIER		1020 W	ADDRESS, CITY, STATE, ZIP COD / VINE ST ETON, 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
K 0331 SS=E Bldg 01	NFPA 101 Interior Wall and C	Ceiling Finish		4. MONITORING CORRECTIVACTION: a. The monitoring results will be presented by the Administrator 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 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 10-20-2023	ne rat
Bldg. 01	exposed interior so as fixed or movable columns, and have Class A or Class E interior finish for a prescribed in 10.2 10.2, 19.3.3.1, 19. Indicate flame spread Based on observation failed to ensure 1 of	eiling finishes, including urfaces of buildings such le walls, partitions, e a flame spread rating of 3. The reduction in class of sprinkler system as .8.1 is permitted.	K 0331	K331– It is the intent of the facto ensure smoke compartmen are provided with a complete	-

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPLETED	
		155275	B. W	ING	09/25/2023		
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			/ VINE ST		
WATER	S OF PRINCETON,	THE			ETON, IN 47670		
WATER	OF FRINCETON,			FIXING	E10N, IN 47070		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	1
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	1 -	g of Class A or Class B for a			interior finish with a flame spr		
		. LSC 3.3.90.4 defines interior			rating of Class A or Class B fo		
		nterior finish of columns, fixed			sprinklered facility to meet set		
		and fixed or movable partitions.			standards.		
		terior finish is not intended to			1 CORRECTIVE ACTIONS	S	
	* * *	vithin spaces such as those			TAKEN:		
		or inaccessible. This deficient			a On 10-18-2023 the		
	_	et mostly staff while in the			Maintenance Supervisor/design	·	
		residents while on the way to			will replace the attic access pa		
	the smoking area.				in the Laundry Room with a fir	re l	
					rated assembly to meet set		
	Findings include:				standards. The		
	D 1 1 1 1 00/07/001				Administrator/designee will ve	rified	
		ons on 09/25/23 between 1:15			the work on 10-18-2023 .		
		during a tour of the facility with			2 ALL OTHERS WITH		
		there was a two foot by two			POTENTIAL TO BE AFFECT		
		access panel in the laundry			a All residents and all staf		
	room. This was ac	- ·			and visitors have the potential	to	
		e time of observation,			be affected but none were.		
		dministrator said the plywood			3 MEASURES TO PREVE	:NT	
	_	lid not have a flame spread			REOCCURRENCE:		
	rating as far as she	knew.			a On 10-9-2023 the		
	This finding was no	rejourned regists the Administration			Administrator/designee in ser	vicea	
	during the exit con	eviewed with the Administrator			the Maintenance		
	during the exit con	referee.			Supervisor/designee on the		
	3.1-19(b)				requirement that smoke compartments are provided w	ith a	
	3.1-17(0)				complete interior finish with a	IIII a	
					flame spread rating of Class A	\ or	
					B for a sprinklered facility to m		
					set standards.		
					b Maintenance		
					Supervisor/designee will ensu	re	
					smoke compartments are pro		
					with a complete interior finish		
					a flame spread rating of Class		
					B for a sprinklered facility as a		
					part of the facility's monthly		
					Preventive Maintenance Prog	ram	
					and document those inspection		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  09/25/2023			
	PROVIDER OR SUPPLIER		1020	FADDRESS, CITY, STATE, ZIP COD W VINE ST CETON, IN 47670	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	THE STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION MEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRICT OF THE APPROPR	vill be ce ew will ance e chly ace g. n by
				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 wit all regulatory requirements.  Our date of compliance is 10-20-2023	as :h
K 0353 SS=F Bldg, 01	, · ,	- Maintenance and Testing			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED			ETED	
		155275	B. W	ING		09/25/	/2023
en en r				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C		1020 W	/ VINE ST		
WATERS	OF PRINCETON,	THE		PRINC	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 APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		er and standpipe systems					
	-	ted, and maintained in					
		NFPA 25, Standard for the					
		g, and Maintaining of					
		Protection Systems.					
		n design, maintenance,					
		sting are maintained in a					
		nd readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	system test					
	c) Water system supply source						
	Provide in REMARKS information on						
	coverage for any	non-required or partial					
	automatic sprinkle	er system.					
	9.7.5, 9.7.7, 9.7.8	, and NFPA 25					
	Based on record rev	view, observation, and	K 0	K 0353 K353 – It is the intent of the			10/20/2023
	interview; the facili	ty failed to document sprinkler			facility to ensure to document		
		in accordance with NFPA 25			sprinkler system inspections ir	1	
		cler system during 30 of the			accordance with NFPA 25 for	dry	
	_	ne sprinkler system's pressure			sprinkler system during 52 for	the	
		7 of the past 12 months for the			sprinkler systems' pressure		
	1 .	ontrol valves. NFPA 25,			gauges and during the past 12		
		spection, Testing, and			months for the sprinkler syster	n's	
		ter-Based Fire Protection			control valves to meet set		
		ion, Section 5.2.4.2 states			standards.		
		sprinkler systems shall be					
		ensure that normal air and			1.CORRECTIVE ACTIONS		
	_	being maintained. Section			TAKEN:		
	5.1.2 states valves a	•			1.On 10-12-2023 the		
		e inspected, tested, and			Maintenance Supervisor/desig		
		dance with Chapter 13.			performed the weekly inspecti	on	
		ites Table 13.1.1.2 shall be			on the facility's dry sprinkler		
		on, testing and maintenance of			system gauges and document		
		onents and trim. Section 4.3.1			the results to meet set standar		
		be made for all inspections,			The Administrator verified the	work	
		nce of the system and its			on 10-12-2023 .		
	L components and sha	all be made available to the			2 On 10-12-2023 the		I

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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. W	ING		09/25/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8					
WATERS	OF PRINCETON,	THE		1020 W VINE ST PRINCETON, IN 47670			
	OI I MINOL ION,			I MINOR	_ 1		
(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	<u> </u>	TAG	DEFICIENCY)		DATE
		risdiction upon request. This			Maintenance Supervisor/desig		
	-	ould affect all residents, staff,			performed the monthly sprinkle		
	and visitors in the f	acility.			system control valves inspecti		
					and documented the results to	)	
	Findings include:				meet set standards. The		
	D 1 1				Administrator verified the work	on	
		review on 09/25/23 between			10-12-2023 .		
	· ·	p.m. with the Administrator			2.ALL OTHERS WITH		
	-	o documentation available to			POTENTIAL TO BE AFFECTE		
		lry sprinkler system gauges			1.All residents and all sta		
	were inspected weekly during 30 of the past 52				and visitors have the potential	το	
	week period. Based on interview at the time of				be affected but none were.	-	
	record review, the Administrator confirmed there was no documentation available to show that the				3.MEASURES TO PREVEN	l	
		gauges have been inspected at			REOCCURRENCE: 1.On 10-9-2023 the		
		30 of the past 52 weeks.					
		ons with the Administrator		Administrator in serviced the Maintenance Supervisor/designee			
		facility between 1:15 p.m. and			on the requirement that the	lilee	
		y had four pressure gauges at			sprinkler system must be prop	orly	
	the sprinkler riser.	y had four pressure gauges at			inspected including the weekly	-	
	the sprinkler riser.				inspection on the facilities dry	′	
	h Based on record	review on 09/25/23 between			sprinkler system gauges and t	he	
		p.m. with the Administrator			monthly sprinkler system conti		
	· ·	no monthly sprinkler system			valves inspection to meet set		
	-	ection documentation for 7 of			standards.		
	-	Based on interview at the			2.Maintenance		
	-	ew, the Administrator confirmed			Supervisor/designee will ensu	re	
		r system inspections on the		the sprinkler system must be		-	
		ng the past 12 months.			properly inspected including th	ne	
		•			weekly inspection on the facility		
	This finding was re	viewed with the Administrator			dry sprinkler system gauges a		
	during the exit conf				the monthly sprinkler system		
	-				control valves inspection as a	part	
	3.1-19(b)				of the facility's Preventive	-	
					Maintenance Program and		
					document those inspection res	sults	
					as appropriate. If any issues		
					discovered, they will be addres		
					and resolved immediately. Th		
			l		Maintenance Supervisor/desig		

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/25/2023	
	PROVIDER OR SUPPLIE		1020 V	ADDRESS, CITY, STATE, ZIP COD V VINE ST ETON, IN 47670		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIA DEFICIENCY)	DATE	
				will review with the Administrate 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 CORRECT ACTION:  1. The inspection results to 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 10-20-2023	will nace hily ace by nase	
K 0363 SS=B Bldg. 01	than required end exits, or hazardou	corridor openings in other closures of vertical openings, us areas resist the passage made of 1 3/4 inch				

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/25/2023
	ROVIDER OR SUPPLIER		1020 W	ADDRESS, CITY, STATE, ZIP COD / VINE ST ETON, 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
	capable of resisting minutes. Doors in compartments are passage of smoke to rooms containing combustible materials hardware. Roller lead to combustible materials and the door seems of the doors complying with the door closed with a complete with the door closed	rials have positive latching atches are prohibited by these requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of the permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,	K 0363	K363 – It is the intent of the	10/20/2023
	failed to ensure 1 of corridor doors would	and interview, the facility  Fat least 20 Service Hall  d close complete and latch  This deficient practice could	K 0303	facility to ensure corridor doors close complete and latch into door frame to meet set standa	s its

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u> completed				
		155275	B. WING		09/25/2023		
			CTREET	CADDRESS SITN STATE ZID SOD			
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD			
\A/A TED	OF PRIMOFTON	THE		W VINE ST			
WATERS	S OF PRINCETON,	IHE	PRINC	PRINCETON, IN 47670			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWINED'S DI AN OF CODDECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	affect mostly staff,	plus any residents going to the		1 CORRECTIVE ACTIONS	s		
	smoking area.			TAKEN:			
				a On 10-9-2023 the			
	Findings include:			Maintenance Supervisor/design	gnee		
				repaired the corridor door to t			
	Based on observation	ons on 09/25/23 between 1:15		Employee Breakroom so the			
	p.m. and 4:15 p.m.	during a tour of the facility with		would self-close and latch full			
		the corridor door to the		into the frame to meet set			
		om did not close completely and		standards. The Administrator	,		
	latch when tested so	everal times. There was a half		verified the work on 10-9-202	3.		
	inch gap between th	ne door and the frame along		2 ALL OTHERS WITH			
	the latching side. E	Based on interview at the time		POTENTIAL TO BE AFFECT	ED:		
	of observation, the Administrator acknowledged			a All residents and all staf	f		
	the Service Hall co	rridor door to the Employee		and visitors have the potentia	l to		
	Breakroom failed to	o close complete and latch into		be affected but none were. T			
	its door frame when			Maintenance Supervisor/design	gnee		
				inspected all corridor doors to			
	This finding was re	viewed with the Administrator		ensure they close and latch fu			
	during the exit conf	ference.		into the frame and found no o			
				negative findings.			
	3.1-19(b)			3 MEASURES TO PREVE	NT		
				REOCCURRENCE:			
				a On 10-9-2023 the			
				Administrator in serviced the			
				Maintenance Supervisor/design	gnee		
				and all staff on the requireme	nt		
				that corridor doors must self-o	lose		
				and latch fully into the frame t	0		
				meet set standards.			
				b Maintenance			
				Supervisor/designee will inspe	ect		
				all corridor doors throughout t	he		
				facility monthly to ensure they	,		
				self-close and latch fully into t	he		
				frame as a part of the facility's	;		
				Preventive Maintenance Prog	ram		
				and document those inspection	on		
				results as appropriate. If any	,		
				issues are discovered, they w	ill be		
				addressed and resolved			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155275	B. Wl	ING	_	09/25/	2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1020 W VINE ST PRINCETON, IN 47670				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDER'S DI AN 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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					immediately. The Maintenand 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 who be presented by the Maintenance Supervisor/designee to 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 10-20-2023.	ill nce hly ce by	
K 0374	NFPA 101	Iding Change Create					
SS=E Bldg. 01	Subdivision of Bui   Barrie	lding Spaces - Smoke					
Diug. 01		lding Spaces - Smoke					
	Barrier Doors	iding Opacca - Official					
	2012 EXISTING						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155275		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  09/25/2023			
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	Doors in smoke be solid bonded wood construction that in Nonrated protective are permitted. Door fixed fire window a are self-closing or require latching, a in the direction of provides a minimular for swinging or how 19.3.7.6, 19.3.7.8. Based on observation failed to ensure 3 of which swing in the with an astragal have functioning coordinated well as staff and visually practice could affect well as staff and visually provided in the self and the self area closed in the self attached to one of the coordinator attached it did not function of it was missing the patents. The set of smoke when closed fully designed in the self attached to self attached to self the self attached to self the self attached to self the self attached fully designed. The set of smoke Crossing" Unit close the self attached to self self	arriers are 1-3/4-inch thick d-core doors or of esists fire for 20 minutes. We plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not not are not required to swing egress travel. Door opening am clear width of 32 inches rizontal doors.  19.3.7.9  In and interview, the facility of 3 set of smoke barrier doors same direction and equipped are a properly equipped and ator to ensure the door which ays closes first. This deficient to more than 20 residents, as	K 0374	K374 – It is the intent of the facility to ensure sets of smoke barrier doors which swing in the same direction and equipped wan astragal have a properly equipped and functioning coordinator to ensure the door which must close first always closes first to meet set standard 1 CORRECTIVE ACTIONS TAKEN:  a On 10-9-2023 the Maintenance Supervisor/design ordered the door coordinator for the smoke barrier doors between the west service hall and 100 conurse's station to meet set standards. The Administrator verified the order on 10—9-2023.  b On 10-9-2023 the Maintenance Supervisor/design ordered the door coordinator for the smoke barrier doors in "the crossing" unit to meet set standards. The Administrator	10/20/2023 elee with  rds. innee or een unit  nnee or		
	was a door coordina	ator attached to the door		verified the order on			

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frame, however, it did not function correctly.

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10-9-2023.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155275	B. W	ING		09/25/	/2023
				CTREET	ADDRESS SITY STATE TIP SOD		
NAME OF F	PROVIDER OR SUPPLIEF	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
VA/A TED	OF PRIMOFTON	THE			/ VINE ST		
WATERS	OF PRINCETON,	THE		PRINCI	ETON, IN 47670		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	When tested, there	was a six inch gap between			c On 10-9-2023 the		
		sed fully due to the faulty			Maintenance Supervisor/desig	nee	
	coordinator.	J J			ordered the door coordinator of	-	
	c. The set of smoke	e barrier doors between the 100			the smoke barrier doors between		
		and the 100 Unit Nurse's			the 100 southwest corridor an		
	Station area closed in the same direction with an				100 unit nurse's station area t		
	astragal attached to one of the doors. There was				meet set standards. The	•	
	a door coordinator attached to the door frame.				Administrator verified the orde	er on	
	The coordinator did function correctly when				10-9-2023.		
		e plastic or rubber wheel of the			d The Coordinators are or	1	
		ssing which could eventually			back order until the 25 at which		
		or to not function correctly.			time they will be installed .	<b>41</b>	
		at the time of observation, the			2 ALL OTHERS WITH		
		ed the coordinators on two of			POTENTIAL TO BE AFFECTI	=D·	
	_	oors did not allow the sets of			a All residents and all staff		
		s to function as designed, and					
		ther coordinator needed the			and visitors have the potential to be affected but none were. On		
		neel to function properly as		10-13-2023 the Maintenance			
	designed.	icer to function property as			Supervisor/designee inspecte	ط ماا	
	designed.				smoke barrier doors througho		
	This finding was re	viewed with the Administrator			the facility and found no other		
	during the exit conf				negative findings.		
	during the exit com	erence.			3 MEASURES TO PREVE	NT	
	2 1 10(b)					IN I	
	3.1-19(b)				REOCCURRENCE:		
					a On 10-9-2023 the		
					Administrator in serviced the		
					Maintenance Supervisor/all	aont	
					staff/designee on the requiren		
					that smoke barrier doors whic		
					swing in the same direction ar		
					equipped with an astragal hav		
					properly equipped and functio	_	
					door coordinator to ensure the		
					door which must close first alv		
					closes first to meet set standa	rds.	
					b Maintenance		
					Supervisor/designee will inspe		
					all smoke barrier doors throug	nout	
					the facility monthly to ensure		
					smoke barrier doors which sw	ing	

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	T OF DEFICIENCIES  DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155275	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COM	e survey pleted 5/2023
	ROVIDER OR SUPPLIE		1020 W	ADDRESS, CITY, STATE, ZIP V VINE ST ETON, IN 47670	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
				in the same direction equipped with an astr properly equipped and door coordinator to er door which must close closes first as a part of facility's Preventive M Program and docume inspection results as a If any issues are discountified with the addressed and immediately. The Ma Supervisor/designee with the Administrator inspection results.  c The Administrator inspection results.  c The Administrator Maintens schedule and validate Preventative Maintens documentation is in part of MONITORING CORRECTIVE ACTION The inspection results at the CORRECTIVE ACTION Administrator will presinspection results at the Quality Assurance/Pellmprovement (QA/PI) Inspection results and components will be rethe QA/PI Committee subsequent plans of developed and implement deemed necessary to compliance is maintain This plan of corrections titutes our credit constitutes our credit	ragal have a d functioning insure the e first always of the laintenance ent those appropriate. Overed, they d resolved intenance will review in the ence lace.  ON: results will Maintenance to the example and the sent the he monthly enformance meeting. It is system eviewed by with correction mented as ensure ined.	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPLI	ETED
		155275	B. WING			09/25/	2023
	PROVIDER OR SUPPLIER		10	020 W	DDRESS, CITY, STATE, ZIP COD VINE ST TON, IN 47670		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	II	D			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)	IE .	DATE
K 0511	NFPA 101	Floatria			allegation of compliance with all regulatory requirements. Our date of compliance is 10-25-2023	1	
SS=D Bldg. 01	complies with NFF Code, electrical wi complies with NFF Code. Existing ins service provided in 18.5.1.1, 19.5.1.1, Based on observation failed to ensure 1 of provided with groun (GFCI) protection a 70, NEC 2011 Edition Circuit-Interrupter Instates, ground-fault personnel shall be p 210.8(A) through (Control of the control of the control informational Notes: circuit interrupter profeeders. (B) Other Than Dwasingle-phase, 15- an installed in the locate through (8) shall had circuit-interrupter profeeders. (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to 6	Electric gas or related gas piping PA 54, National Fuel Gas ring and equipment PA 70, National Electric tallations can continue in to hazard to life. 9.1.1, 9.1.2 on and interview, the facility Fover 10 wet locations, was and fault circuit interrupter gainst electric shock. NFPA on at 210.8 Ground-Fault Protection for Personnel, circuit-interruption for rovided as required in C). The ground-fault mall be installed in a readily See 215.9 for ground-fault rotection for personnel on elling Units. All 125-volt, dd 20-ampere receptacles tions specified in 210.8(B)(1)	K 0511		K511 – It is the intent of the facility to ensure wet locations provided with ground fault circ interrupter (GFCI) protection against electric shock to meet standards.  1 CORRECTIVE ACTIONS TAKEN: 2 On 1011-2023 the Maintenance Supervisor/designstalled a GFCI receptacle in east unit clean utility room to meet set standards. The Administrator verified the repart on 10-11-2023 ALL OTHERS WITH POTENTIAL TO BE AFFECTED:  a All residents and all staff and visitors have the potential be affected but none were. On 10-11-2023 the Maintenance Supervisor/designee inspected electrical outlets and found no other negative findings.  3 MEASURES TO PREVE	set  Set  Genee  The  The  The  The  The  The  The	10/20/2023

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CENTERS FOR	AID SERVICES				OMB NO. 0938-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	01	COMPL	ETED
		155275	B. WING			09/25/	2023
			CT	DEETA	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			VINE ST		
\\/\TED	OF PRINCETON,	TUE			ETON, IN 47670		
WATER	OF FRINCE ION,			TINCE	= 1 ON, IN 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	PREI	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TA	.G	DEFICIENCY)		DATE
	branch circuit dedic	eated to electric snow-melting,			REOCCURRENCE:		
	deicing, or pipeline	and vessel heating equipment			a On 10-9-2023 the		
	shall be permitted to	o be installed in accordance			Administrator in serviced the		
	with 426.28 or 427.	22, as applicable.			Maintenance Supervisor/desig	nee	
	Exception No. 2 to	(4): In industrial establishments			on the requirement that wet		
	only, where the con	ditions of maintenance and			locations are provided with GF	CI	
	supervision ensure	that only qualified personnel			receptacles to protect against		
	are involved, an ass	ured equipment grounding			electrical shock to meet set		
	conductor program	as specified in 590.6(B)(2)			standards.		
	shall be permitted f	or only those receptacle			a Maintenance		
	outlets used to supp	ly equipment that would			Supervisor/designee will inspe	ect	
	create a greater haz	ard if power is interrupted or			all wet locations to ensure they		
	having a design that	t is not compatible with GFCI			are provided with GFCI		
	protection.				receptacles to protect against		
	(5) Sinks - where re	eceptacles are installed within			electrical shock as a part of the	е	
		outside edge of the sink.			facility's monthly Preventive		
		(5): In industrial laboratories,			Maintenance Program and		
	_	supply equipment where			document those inspection res	sults	
	_	vould introduce a greater			as appropriate. If any issues		
	_	nitted to be installed without			discovered, they will be addres		
	GFCI protection.				and resolved immediately. Th		
	Exception No. 2 to	(5): For receptacles located in			Maintenance Supervisor/desig		
	patient bed location	s of general care or critical			will review with the Administra		
	_	care facilities other than those			the inspection results.		
	covered under				b The Administrator will		
	210.8(B)(1), GFCI	protection shall not be required.			monitor adherence to the		
	(6) Indoor wet locat				Preventative Maintenance		
	(7) Locker rooms w	vith associated showering			schedule and validate the		
	facilities				Preventative Maintenance		
	(8) Garages, service	e bays, and similar areas where			documentation is in place.		
	electrical				4.MONITORING CORRECTIVI	E	
	diagnostic equipme	nt, electrical hand tools.			ACTION:		
		Vet Locations, requires all			c The inspection results wi	II	
		ed equipment within the area of			be presented by the Maintena		
		have ground-fault circuit			Supervisor/designee to the		
		protection. Note: Moisture can			Administrator monthly and the		
		resistance of the body, and			Administrator will present the		
		is more subject to failure.			inspection results at the month	nly	

This deficient practice could affect one staff while

in the East Unit Clean Utility Room.

Quality Assurance/Performance

Improvement (QA/PI) meeting.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155275		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/25/2023
		1020 W	V VINE ST	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
p.m. and 4:15 p.m. of the Administrator, to four feet of the sink Room was not prov. When tested with a receptacle did not be Based on interview Administrator agree Unit Clean Utility Reprotected.  This finding was reduring the exit confidence of the confidence of	during a tour of the facility with the electric receptacle within in the East Unit Clean Utility ided with a GFCI receptacle.  GFCI testing device the reak the electrical circuit. at the time of observation, the electrical in the East the three to the receptacle in the East three was not properly GFCI wiewed with the Administrator erence.		components will be reviewed the QA/PI Committee with subsequent plans of correctic developed and implemented deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance wi	by on as th
conditions, at leas The staff is familia aware that drills ar routine. Where dr 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1 1. Based on record facility failed to pro documentation for I quarters. This defice	t quarterly on each shift. r with procedures and is re part of established ills are conducted between AM, a coded ay be used instead of  9.7.1.7 review and interview, the vide quarterly fire drill of 3 shifts during 1 of 4 ient practice could affect all	K 0712	for all shifts every quarter and	d to
	PROVIDER OR SUPPLIER SOF PRINCETON,  SUMMARY SOF (EACH DEFICIEN REGULATORY OR  Findings include:  Based on observation p.m. and 4:15 p.m. of the Administrator, to four feet of the sink Room was not provous When tested with a receptacle did not be Based on interview Administrator agree Unit Clean Utility Reprotected.  This finding was reduring the exit confidence of the sink Room was not provous When tested with a receptacle did not be Based on interview Administrator agree Unit Clean Utility Reprotected.  This finding was reduring the exit confidence of the sink Room was not provous Room of the staff is finding was reduring the exit confidence of the staff is familia aware that drills are routine. Where dressed in the staff is familia aware that drills are routine. Where dressed in the staff is familia aware that drills are routine. Where dressed in the staff is familia aware that drills are routine. Where dressed in the staff is familia aware that drills are routine. Where dressed in the staff is familia aware that drills are routine. Where dressed in the staff is familia aware that drills are routine. Where dressed in the staff is familia aware that drills are routine. Where dressed in the staff is familia aware that drills are routine. Where dressed in the staff is familia aware that drills are routine. Where dressed in the staff is familia aware that drills are routine. The staff is familia aware that drills are routine. The staff is familia aware that drills are routine. The staff is familia aware that drills are routine. The staff is familia aware that drills are routine. The staff is familia aware that drills are routine. The staff is familia aware that drills are routine. The staff is familia aware that drills are routine. The staff is familia aware that drills are routine. The staff is familia aware that drills are routine. The staff is familia aware that drills are routine. The staff is familia aware that drills are routine.	DENTIFICATION NUMBER 155275  PROVIDER OR SUPPLIER  SOF PRINCETON, THE  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Findings include:  Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, the electric receptacle within four feet of the sink in the East Unit Clean Utility Room was not provided with a GFCI receptacle. When tested with a GFCI testing device the receptacle did not break the electrical circuit. Based on interview at the time of observation, the Administrator agreed the receptacle in the East Unit Clean Utility Room was not properly GFCI protected.  This finding was reviewed with the Administrator during the exit conference.  3.1-19(b)  NFPA 101  Fire Drills  Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of	STREET 1020 V PRINCE  ROVIDER OR SUPPLIER  SOF PRINCETON, THE  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Findings include:  Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, the electric receptacle within four feet of the sink in the East Unit Clean Utility Room was not provided with a GFCI receptacle. When tested with a GFCI testing device the receptacle did not break the electrical circuit. Based on interview at the time of observation, the Administrator agreed the receptacle in the East Unit Clean Utility Room was not properly GFCI protected.  This finding was reviewed with the Administrator during the exit conference.  3.1-19(b)  NFPA 101  Fire Drills  Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift.  The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.  19.7.1.4 through 19.7.1.7  1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all	DENTIFICATION NUMBER 155275  ROVIDER OR SUPPLIER S OF PRINCETON, THE  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION  Findings include:  Findings include:  Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, the electric receptacle within four feet of the sink in the East Unit Clean Utility Room was not provided with a GFCI receptacle. When tested with a GFCI testing device the receptacle did not break the electrical circuit. Based on interview at the time of observation, the Administrator agreed the receptacle in the East Unit Clean Utility Room was not properly GFCI protected.  This finding was reviewed with the Administrator during the exit conference.  3.1-19(b)  NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions, Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.  19,7.1.4 through 19.7.1.7  1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	TED
		155275	B. W	ING		09/25/2	023
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			/ VINE ST		
WATER	S OF PRINCETON,	THE			ETON, IN 47670		
WAILN		1116	_	1 ININO	_ 1 O 1		
(X4) ID	SUMMARY	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 APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	facility.				complete transmission of a fir		
					alarm signal to the monitoring		
	Findings include:				company/fire department duri	-	
					the past twelve months to me	et	
		the facility's fire drill reports			set standards.		
	on 09/25/23 between 9:35 a.m. and 1:15 p.m. with				1 CORRECTIVE ACTION	S	
	the Administrator present, the facility lacked fire				TAKEN:		
	drill documentation for the first shift (day) of the				a On 10-9-2023 the		
	• `	ober, November, and			Administrator in serviced the		
	1	. Based on interview at the time			Maintenance Supervisor/design	-	
		ne Administrator confirmed the			on the requirement that fire dr		
		eport during the first shift of the			must be conducted at unexpe		
	fourth quarter of 20	022.			times under varying condition		
					least quarterly on each shift a	nd	
		eviewed with the Administrator			documented to meet set		
	during the exit conf	ference.			standards.		
					b On 10-16-2023 the		
	3.1-19(b)				Maintenance Supervisor/design	-	
	3.1-51(c)				will conduct a fire drill for each		
	l				the three shifts and document		
		review and interview, the			the results in the facilities Life		
	1	sure 8 of 11 fire drill reports			Safety Binder to meet set		
	•	documentation of the			standards. The Administrat		
		re alarm signal to the			will verify the drills on 10-16-2	2023	
		ny/fire department during the			c On 10-9-2023 the		
		. LSC 19.7.1.4 requires fire			Administrator in serviced the		
		occupancies shall include the			Maintenance Supervisor/design	- I	
		fire alarm signal and			on the requirement that fire dr		
		gency conditions. This			reports must have documenta		
	deficient practice co	ould affect all residents.			for the transmission of the ala	ırm	
					to the monitoring company to		
	Findings include:				meet set standards.		
	D 1				2 ALL OTHERS WITH	_	
		the facility's fire drill reports			POTENTIAL TO BE AFFECT		
		en 9:35 a.m. and 1:15 p.m. with			a All residents and all staf		
	_	present, 8 of 11 fire drill reports			and visitors have the potentia	I TO	
	_	he past 12 month period were			be affected but none were.		
	-	locumentation for the			3 MEASURES TO PREVE	:NT	
		alarm to the monitoring			REOCCURRENCE:		
	company. These di	rills were all performed during			a Maintenance		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	<u>01</u>	COMPL	ETED
		155275	B. W	ING		09/25/	2023
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
VA/A TED C	OF PRIMOFTON	THE			VINE ST		
WATERS	OF PRINCETON,	THE		PRINCE	ETON, IN 47670		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T.C.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	the second and third	d shifts. Based on interview at			Supervisor/designee will ensu	re	
	the time of record re	eview, the Administrator			fire drills are conducted at		
	acknowledged there was no information on the				unexpected times under varyir	na	
	eight fire drill reports to verify that transmission of				conditions at least quarterly or	•	
	the alarm was received by the monitoring				each shift and that documenta		
	company.				be retained in the facility's Life		
		1 3			Safety Binder and all reports v		
	This finding was reviewed with the Administrator during the exit conference.				have documentation for the		
					transmission of the alarm to the	e	
		erenee.			monitoring company as a part		
	3-1.19(b)				the facility's Preventive	-1	
	3.1-51(c)				Maintenance Program and		
	3.1 31(0)				document those inspection res	culte	
					as appropriate. If any issues		
					discovered, they will be address		
					and resolved immediately. Th		
					Maintenance Supervisor/desig		
					will review with the Administra		
						lOI	
					the inspection results. b The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4 MONITORING		
					CORRECTIVE ACTION:	:11	
					a The inspection results w		
					be presented by the Maintena	nce	
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the	. I	
					inspection results at the month	-	
					Quality Assurance/Performand		
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed to	ру	
					the QA/PI Committee with		
					subsequent plans of correction		
					developed and implemented a	s	

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Event ID:

QWKE21 Facility ID: 000175

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155275		A. BUILDING B. WING	01	COMPLETED 09/25/2023	
NAME OF PROVIDER OR S			1020 W	ADDRESS, CITY, STATE, ZIP COD V VINE ST ETON, IN 47670	_
PREFIX (EACH D	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
				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 10-20-2023.	1
Bldg. 01 Extens Electrical Extension Power strip used for co patient-car (PCREE) a assembled the condition the patient non-PCRE except in lo do not use meet UL 13 for non-PC (outside of non-patien other UL si used with of cords are r wiring of a temporarily completion installed ar 10.2.3.6 (N (NFPA 70) Based on of failed to ens	Equipme Cords os in a pompone re-relate assemblated by qual ons of 1 care viries (e.g., cong-terr PCREE 363A or REE in vicinity t care related general not used structure a of the ind meet lFPA 98 1, 590.3 (bservationsure a miles)	ent - Power Cords and ent - Power Strips in continuous ent	K 0920	K920– It is the intent of the facility to ensure multi plug adapter is not used as a	10/20/2023

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	
		155275	B. WI	NG		09/25/	2023
NAME OF T	DROWNED OF CURPUSE			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIER			1020 W	/ VINE ST		
WATERS	OF PRINCETON,	THE		PRINCI	ETON, IN 47670		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
		requires utilities to comply with .1.2 requires electrical wiring			substitute for fixed wiring in resident rooms to meet set		
		omply with NFPA 70, National			standards.		
		11 Edition. NFPA 70, Article			1 CORRECTIVE ACTIONS	,	
		unless specifically permitted,			TAKEN:		
	_	ables shall not be used as a			a On 9-25-2023 the		
	substitute for fixed wiring of a structure. This				Maintenance Supervisor/design	gnee	
	deficient practice co	ould affect one resident in			removed the multi plug adapte	er in	
	room 215.				resident room 215 to meet set	t	
					standards. The Administrator		
	Findings include:				verified the removal of the cor	d on	
					9-25-2023		
	Based on observations on 09/25/23 between 1:15				2 ALL OTHERS WITH		
		during a tour of the facility with			POTENTAL TO BE AFFECTE		
	the Administrator, t				a All residents and all staf		
		bulizer plugged into a			and visitors have the potential	to	
		as plugged into the wall		be affected but none the			
	_	nt room 215. Based on			Maintenance Supervisor/desig	-	
		e of observation, the			inspected all rooms throughou		
		owledged the use of the			facility for multi plug adapters		
	muiti-piug adapter i	n resident room 215.			found no other negative findin  3 MEASURES TO PREVE	-	
	This finding was re	viewed with the Administrator			3 MEASURES TO PREVE REOCCURRENCE:	in i	
	during the exit conf				a On 9-25-2023 the		
	and the one oom				Administrator in serviced the		
	3.1-19(b)				Maintenance Supervisor/desig	nee l	
					and all other staff on the	,	
					requirement that multi plug		
					adapters are not to be used in	the	
					facility to meet set standards.		
					b Maintenance		
					Supervisor/designee will inspe	ect	
					all rooms throughout the facili	ty	
					monthly and remove any mult		
					plug adapters found as a part	of	
					the facility's Preventive		
					Maintenance Program and		
					document those inspection re-		
					as appropriate. If any issues		
l	l				discovered they will be addre	ssed	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155275	B. WI	NG		09/25/	/2023
	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)	TE	(X5) COMPLETION DATE
	REGULTION TON				and resolved immediately. The Maintenance Supervisor/design will review with the Administrative inspection results.  The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  MONITORING CORRECTIVE ACTION:  The inspection results whe presented by the Maintenan Supervisor/designee to 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 to 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 10-20-2023.	ill nce hly ce by	

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