

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155753	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2014
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NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170
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K010000	<p>A Life Safety Code Recertification and State Licensure survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/18/14</p> <p>Facility Number: 004902 Provider Number: 155753 AIM Number: 200813130</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hampton Oaks Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all</p>	K010000	<p>December 10, 2014 Hampton Oaks Health Campus 966 North Wilson Road Scottsburg, Indiana 47170 Survey Event ID 000021. The submission of the Plan of correction does not indicate an admission by Hamtpon Oaks Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Hamtpon Oaks Health Campus. This facility recognized it's obligation to provide legally and medically necessary care an services to its residents in an economic and efficient manner. The facility herby maintains it is in substantial compliance with the requirements of participation for cmprehensive health care facilities (for Title 18/19 programs). Attached you will find our Plan of Correction for Hampton Oaks Health Campus for our annual revisit survey conducted on November 18, 2014. We initited immediate intervention when concerns were identified on this date. We respectfully request paper review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812) 752-2694.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiencystatement 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.

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K010011 SS=F	<p>resident sleeping rooms. The healthcare portion of the facility has a capacity of 71 and had a census of 63 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/03/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2</p> <p>Based on observation and interview, the facility failed to provide a two hour fire rated separation in 1 of 1 two hour fire rated wall between the Health Center and the assisted living occupancy with firestopped fire barrier penetrations. This</p>	K010011	Findings indicated that the Fire wall barrier located at the attic access panel in the kitchen, had a 4' X 3' section missing. On 12/12/14 the 4' X 3' section missing was replaced by DPO. DPO and ED will verify when an outside agency enters attic to	12/12/2014

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	<p>deficient practice could affect all healthcare residents in the event of a fire in the fire barrier located above the kitchen, which extends above the ceiling along the main dining room to the Service Hall.</p> <p>Findings include:</p> <p>Based on observation on 11/18/14 at 12:20 p.m. with the director of plant operations, the fire barrier wall, located at the attic access panel in the kitchen, had a four foot by three foot rectangular area of double drywall missing on each side of the wooden truss in the center of the fire barrier wall. Based on an interview with the director of plant operations on 11/18/14 at 12:30 p.m., the fire barrier wall was cut a month ago by a heating contractor, who was conducting a repair on the other side of the wall and the wall was not repaired. Furthermore, the fire barrier wall had a fire barrier set of doors in the Service Hall, which were used as a horizontal exit according to the evacuation map posted on the kitchen wall. The four foot by three foot area of double drywall missing on each side of the fire barrier wall above the kitchen was verified by the director of plant operations at the time of observation and acknowledged by the administrator at the exit conference on 11/18/14 at 1:20 p.m.</p>		<p>ensure fire wall barrier has not been altered or damaged. Findings will be reported to QA monthly X 3 months or until 100% compliance has been achieved. Peer review is conducted every 6 months by Home Office support and this will serve as an additional monitoring process to insure compliance.</p>	

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K010025 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barrier was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 36 residents who use the main corridor intersection at the central nurses station.</p> <p>Findings include:</p> <p>Based on observations with the director of plant operations on 11/18/14 during a tour of the facility from 9:10 a.m. to 1:15 p.m., the following ceiling and wall smoke barriers had missing drywall or were not fire stopped;</p> <p>a. The Service Hall boiler room ceiling</p>	K010025	<p>Findings include 2 areas that lacked wall smoke barriers. The first area identified was Service Hall Boiler room ceiling identified a 1/2" gap around a water pipe penetration not fire stopped. This was corrected on 12/12/2014 by using 3M Fire barrier caulking to close the 1/2" gap. The second area was the communication room ceiling, located next to the central nurses' station, had a one half inch gap around an electrical conduit penetration, not fire stopped. This was corrected on 12/12/2014 by using the 3M fire barrier caulking to close the gap. DPO will do walking rounds quarterly to ensure there have not been gaps created based upon the settling of the building. Findings would be corrected and findings reported to QA. Peer review is conducted every 6 months by home office support</p>	12/12/2014			

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K010029 SS=E	<p>had a one half inch gap around a water pipe penetration not fire stopped.</p> <p>b. The communication room ceiling, located next to the central nurses' station, had a one half inch gap around an electrical conduit penetration not fire stopped.</p> <p>The Service Hall boiler room ceiling and the communication room ceiling penetrations not fire stopped were verified by the director of plant operations at the time of observations and acknowledged by the administrator at the exit conference on 11/18/14 at 1:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on observations and interview, the facility failed to ensure 1 of 4 corridor doors to combustible storage rooms over 50 square feet was provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 36 residents who use</p>	K010029	<p>and this will serve as an additional monitoring process to ensure compliance.</p> <p>Findings indicated that the Nursing Supply Storage unit did not have a self closure on door. Based upon the size of the room under Federal regulations a self closure is required. DPO on 12/10/2014 placed a self closure to the door. DPO has completed a full house audit and verified that we are 100% in compliance and</p>	12/10/2014

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K010038 SS=E	<p>the main corridor intersection at the central nurses station.</p> <p>Findings include:</p> <p>Based on observation on 11/18/14 at 11:45 a.m. with the director of plant operations, the nursing supply room, which measured eighty square feet and stored four shelves of combustible paper, cotton tipped applicators, cardboard boxes of plastic bandages, plastic oxygen supplies, and plastic catheters, lacked a self closing device on the door. This was verified by the director of plant operations at the time of observation and acknowledged by the administrator at the exit conference on 11/18/14 at 1:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 8 exit door electromagnetic locks remained unlocked while the fire alarm was activated and silenced. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be</p>	K010038	<p>all doors are appropriate to code. DPO educated on room size and regulations for use of a self closure. DPO and ED will audit doors weekly and will report findings to QA monthly X next 3 months or until 100% compliance has been achieved. Peer review is conducted every 6 months by home office support and this will serve as an additional monitoring process to ensure compliance.</p> <p>Findings indicated that 2 of the 8 exit doors electromagnetic locks remained locked while the fire alarm was activated. DPO replaced the mother board and power supply on the 200 hall door and replaced the fire relay on the door in the back hallway. DPO does a daily check on all exit</p>	11/24/2014

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	<p>in accordance with Chapter 7. LSC 7.2.1.6.2 requires, where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice affects 18 residents who reside on 200 Hall.</p> <p>Findings include:</p> <p>Based on observations during a test of the fire alarm system on 11/18/14 with the director of plant operations at 1:00 p.m., the electromagnetic lock on the Service Hall courtyard exit door and the 200 Hall exit door failed to release and unlock when the fire alarm was activated, and stayed locked when the fire alarm was silenced but not reset. This was verified by the director of plant operations at the time of observations and acknowledged by the administrator at the exit conference on 11/18/14 at 1:20 p.m.</p> <p>3.1-19(b)</p>		doors to ensure they are in good working order and are operating as required. DPO or ED will report findings to QA monthly. Peer Review is conducted every 6 months by Home Office support and this will serve as an additional monitoring process to ensure compliance.		

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K010046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 battery backup light was tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 18.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility during a power outage.</p> <p>Findings include:</p> <p>Based on observation on 11/18/14 at 9:50</p>	K010046	Fingings indicated that there was an emergency light in the mechanical room. Facility failed to do a montly emergency battery light testing log or an annual ninety minute test log. Based upon the fact that the generator is located outside of the buidling it is not required that the backup emergency light is needed. On 11/24/2014 the light was removed and wall repaired. On audit the facility has no other emergency lighting within the campus that would required this type of testing. DPO or ED will do walk thru monthly to ensure no other emergency lighting has not been placed in campus. Peer review is conducted every 6 months by home office support and this will serve as an additional monitoring process to ensure compliance.	11/24/2014

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K010062 SS=E	<p>a.m. with the director of plant operations, there was an emergency battery backup light located in the transfer switch room during record review. Based on an interview with the director of plant operations on 11/18/14 at 10:00 a.m., there is no monthly emergency battery light testing log or an annual ninety minute test log for the emergency battery backup light in the transfer switch room. The lack of a monthly test log and an annual ninety minute test for the transfer switch room battery backup light was verified by the director of plant operations at the time of observation and interview and acknowledged by the administrator at the exit conference on 11/18/14 at 1:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 4 of over 300 sprinklers covered in corrosion were replaced. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for</p>	K010062	Findings indicate that 4 out of 25 outside sprinkler heads were green with corrosion upon inspection. Landmark sprinkler is our contracted service and will replace all 4 sprinkler heads on 12/22/2014. DPO will make walking rounds monthly to ensure	12/22/2014			

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K010144 SS=F	<p>the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 11 residents who use the restorative dining room exit.</p> <p>Findings include:</p> <p>Based on observation on 11/18/14 at 10:55 a.m., the restorative dining room exit overhang had four sprinklers completely covered in green corrosion. This was verified by the director of plant operations at the time of observation and acknowledged by the administrator at the exit conference on 11/18/14 at 1:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than</p>	K010144	<p>sprinklers are in good working condition and will report findings to QA monthly. Peer review is conducted every 6 months by the home office support and this will serve as an additional monitoring process to ensrue compliance.</p> <p>Findings indicate that the load test on the generator was not being recorded on a weekly basis. Cummins Crosspoint LLC is our contracted company who services our generator. On 12/15/2014 Cummins completed an annual inspection as well as</p>	12/15/2014			

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	<p>30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of the Weekly Generator Log with the director of plant operations on 11/18/14 at 9:30 a.m., the Weekly Generator Log listed a weekly inspection of the emergency generator including water levels, oil</p>		<p>a load bank test on the generator and is now on contract to complete on an annual basis. Please see the attached contract and service invoice. The DPO will continue to monitor the generator check weekly and report to QA monthly. Peer review is conducted every 6 months by home office support and this will serve as an additional monitoring process to ensure compliance.</p>	

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	<p>levels, battery test, and fuel level of the fuel tank. Based on an interview with the director of plant operations on 11/18/14 at 9:40 a.m., the generator starts up weekly and runs for thirty minutes but there is no load test log documented to verify a monthly load test is conducted. The lack of monthly load tests on the emergency generator was verified by the director of plant operations at the time of record review and interview, and acknowledged by the administrator at the exit conference on 11/18/14 at 1:20 p.m.</p> <p>3.1-19(b)</p>				