

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155753	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170
----------------------------------------------------------------	----------------------------------------------------------------------------------

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

K 0000 Bldg. 01	<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: 10/07/15</p> <p>Facility Number: 004902 Provider Number: 155753 AIM Number: 200813130</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 resident sleeping rooms. The healthcare portion of the facility has a capacity of 71</p>	K 0000	<p>October 7, 2015 Hampton Oaks Health Campus 966 North Wilson Road Scottsburg, Indiana 47170 Survey Event ID: PCVM21. The submission of the Plan of Correction does not indicate an admission by Hampton 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 Hampton 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 comprehensive health care facility (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 October 7, 2015. We intitiated 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 hesistate to contact us at (812) 752-2694.</p>	
------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

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

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

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 10/07/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170
----------------------------------------------------------------	----------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0130 SS=A Bldg. 01	<p>and had a census of 26 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 completed on 10/09/15 - DA</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 battery backup light in the maintenance office 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 Section 4.6.12.3 requires equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. 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</p>	K 0130	<p>It was identified that the back up lighting log test for both 30 day and annually was not available for the maintenance room only from the months of September 2014 to August 2015. This was identified and corrected for the month of September 2015. The DPO was educated by ED and DPO support. Immediate correction was implemented on maintenance room. Emergency lighting log initiated for a 30(sec) monthly check and 90(min) annual check is now in place, beginning September 2015. Please see the attached documentation. Monthly follow up to ensure emergency testing has been conducted and will be reported to QA monthly X 3 months or until 100% compliance has been completed. Peer review is conducted every 6 months by Home Office support and this will serve as an</p>	10/24/2015

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>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 affects only maintenance staff who work in the maintenance office and no residents.</p> <p>Findings include:</p> <p>Based on record review on 10/07/15 at 9:00 a.m. with the director of plant operations and divisional director of plant operations, the Battery Operated Emergency Light Test Log indicted one monthly test of the maintenance office battery backup light conducted on 09/28/15 and lacked a monthly test for the previous eleven months over the past year. Furthermore, there was no ninety minute test conducted on the maintenance office battery backup light over the past year. Based on an interview with the director of plant operations and divisional director of plant operations on 10/07/15 at 9:20 a.m., the Battery Operated Emergency Light Test Log records over the past year dating before 09/28/15 were missing after the previous director of plant operations left employment at the facility. The lack of monthly load tests of the maintenance office battery backup light for eleven of the past twelve months and a ninety</p>		additional monitoring process to ensure compliance.		

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 10/07/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170
----------------------------------------------------------------	----------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0144 SS=F Bldg. 01	<p>minute annual test was verified by the director of plant operations and divisional director of plant operations at the time of record review and interview and acknowledged by the divisional director of plant operations at the exit conference on 10/07/15 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.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test was conducted on the emergency generator set for 10 of the past 12 months. 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</p>	K 0144	<p>It was identified that the back up lighting log test for both 30 day and annually was not available for the maintenance room only from the months of September 2014 to August 2015. This was identified and corrected for the month of September 2015. The DPO was educated by ED and DPO support. Immediate correction was implemented on maintenance room. Emergency lighting log initiated for a 30(sec) monthly check and 90(min) annual check is now in place, beginning September 2015. Please see the attached documentation. Monthly follow up to ensure emergency testing has been conducted and will be reported to QA monthly X 3 months or until 100% compliance has been completed. Peer review is conducted every 6</p>	10/24/2015

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 10/07/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170
----------------------------------------------------------------	----------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>recommended by the manufacturer. 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 a review of the Monthly Generator Test Log with the director of plant operations and divisional director of plant operations on 10/07/15 at 9:15 a.m., the Monthly Generator Test Log for the past year listed a monthly load test conducted on 08/26/15 and 09/30/15 and lacked a monthly load test for the previous ten months dating back to September 2014. Based on an interview with the director of plant operations and divisional director of plant operations on 10/07/15 at 9:30 a.m., the Monthly Generator Test Log records over the past year dating before 08/26/15 were missing after the previous director of plant operations left employment at the facility. The lack of monthly load tests for the emergency generator from September 2014 through July 2015 was verified by the director of plant operations and divisional director of plant operations at the time of record review and interview, and acknowledged by the divisional director of plant operations at the exit</p>		<p>months by Home Office support and this will serve as an additional monitoring process to ensure compliance.</p>	

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	conference on 10/07/15 at 1:20 p.m. 3.1-19(b)				