STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 00 B. WING	01/09/2024

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

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: January 2, 3, 4, 5, 8, and 9, 2024 Facility number: 004902 Provider number: 155753 AIM number: 200813130 Census Bed Type: SNF/NF: 44 SNF: 21 Residential: 22 Total: 87 Census Payor Type: Medicare: 17 Medicaid: 32 Other: 16 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 16, 2024.	F 0000	On January 9, 2024, Hampton Oaks Health Campus 966 North Wilson Road Scottsburg, Indiana 47170 Survey Event ID 665Q11. The submission of this 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 its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). Attached you will find our Plan of Correction for Hampton Oaks Health Campus for our annual survey conducted on September 23, 2014. We initiated immediate interventions 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. Sincerely, Brandy Royalty, Executive Director.	

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

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F 0623 SS=E Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is			

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	required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill			

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	Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to ensure 5 of 6 residents or responsible parties were provided written notice of Transfer/Discharge upon transfer to an acute care facility. (Residents 9, 67, 21, 12, and 272) Findings include: 1. The record for Resident 9 was reviewed on 1/8/24 at 9:08 a.m. The diagnoses included, but were not limited to, altered mental status, hypertensive heart disease with heart failure, acute systolic (congestive) heart failure, fluid overload, and acute pulmonary edema. The Admission Minimum Data Set (MDS) assessment, dated 10/25/23, indicated the resident's cognition was severely impaired.	F 0623	**1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** **No adverse effects occurred to residents due to alleged deficient practices.** **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s)will be taken?** **All residents who transfer or discharge have the potential to be affected by the alleged deficient practice. All nursing staff who transfer patients were**	01/29/2024

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	A nurse's note, dated 10/21/23 at 1:55 p.m., indicated the resident had a change in condition with increased confusion and lethargy; Labored breathing, shortness of air, and flushed skin. Her colostomy was observed to have bright red tinged substances with a foul odor. The resident was unable to answer questions regarding pain or discomfort. The physician was notified and new orders were received to transfer the resident to the hospital emergency room. The family was made aware of the transfer. Documentation lacked to indicate the resident or the responsible party were given written notice upon the resident's transfer to the hospital, of the reasoning for the resident to be transferred to the hospital or which hospital she was going to. 2. The record for Resident 67 was reviewed on 1/3/24 at 1:46 p.m. The diagnoses included, but were not limited to, pain in left shoulder, generalized muscle weakness, abnormalities of gait and mobility, other symptoms and signs involving cognitive functions and awareness, and Alzheimer's disease. The Admission MDS assessment, dated 9/26/23, indicated the resident's cognition was severely impaired. The nurse's note, dated 10/6/23 at 8:01 p.m., indicated the resident had become very aggressive and combative during the shift with multiple requests to go home. All efforts at redirection failed. After the nurse then sat with the resident to give her time to vent her feelings and check for safety, she went back to the nurse's station to call the family to come in. The nurse then heard a loud noise from the resident's room and found the resident laying on her back. She		**in-serviced on the transfer policy by DHS.** 3 What measures will be put into place, and what systemic changes will be made to ensure the deficient practice does not recur? **As a measure of ongoing compliance, DHS or designee will audit all transferred or discharged residents in CCM for proper notification of transfer or discharge to resident or responsible party 5x/week x 4 weeks, 3/week x 3 months, and 1x/week x 2 months.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** **As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.**	

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	then rolled to her side with her head resting on the bed frame and yelled to go home. Upon assessment, the resident indicated her back was hurting and began vomiting on herself. She further indicated she was unable to have the nurse touch her back and began having labored breathing and feeling dizzy. While another nurse was helping assess the resident, the resident vomited a second time and was combative. The physician was notified and gave new orders for the resident to be sent to a special hospital for evaluation and treatment. While EMS (Emergency Medical Services) was evaluating and assisting the resident to the stretcher, she vomited a third time. Family was notified of the event. Documentation lacked to indicate the resident or the responsible party were given written notice upon transfer to the hospital, of the reasoning for the resident to be transferred to the hospital or which hospital she was going to. During an interview on 1/5/24 at 1:53 p.m., the Regional Director of Clinical Operations indicated she was unable to locate a copy of the Notice of Transfer/Discharge for Resident 67. 3. The record for Resident 21 was reviewed on 1/4/24 at 9:22 a.m. The diagnoses included, but were not limited to, displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus with diabetic neuropathy, unspecified, age-related osteoporosis, unspecified fall, and other abnormalities of gait and mobility. The Quarterly MDS assessment, dated 8/18/23, indicated the resident was alert and oriented.			

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	The nurse's note, dated 10/11/23 at 4:00 p.m., indicated that while holding onto the bar in the bathroom in order to be transferred onto the toilet by the CNA (Certified Nurse Aide), the resident's left leg gave out and buckled. The CNA was unable to hold the resident up and the resident fell to the floor and landed on her left hip. The resident was assisted into bed and began to complain of left hip and knee pain. The physician, family and management were notified and new orders were received to obtain an X-ray of the left hip and knee and continue to monitor the resident. A nurse's note, dated 10/11/23 at 5:48 p.m., indicated the resident was in bed resting and administered pain medication as ordered. The X-ray results were pending. A nurse's note, dated 10/11/23 at 11:41 p.m., indicated the X-ray results showed an acute left intertrochanteric hip fracture. Physician was notified and gave an order to send the resident to the hospital. Family was called and informed. Documentation lacked to indicate the resident or the responsible party were given written notice upon transfer to the hospital, of the reasoning for the resident to be transferred to the hospital or which hospital she was going to. During an interview on 1/5/24 at 1:30 p.m. with LPN (Licensed Practical Nurse) 2, she indicated the face sheet, EMS transfer form, list of medications, a copy of the continuity of care form (CCD) and a copy of the Notice of Transfer/Discharge was put into the packet and sent with the resident to the hospital. She did not give the resident or the family a copy of the Notice of Transfer/Discharge.			

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	4. The record for Resident 12 was reviewed on 1/4/24 at 10:35 a.m. The diagnoses included, but were not limited to, senile degeneration of brain, cardiomegaly, chronic kidney disease stage, Alzheimer's disease with late onset, dementia, disorientation, osteoarthritis, fall, palliative care, sepsis, dementia with agitation, encephalopathy, history of falling, fracture of the neck of left femur. The Significant Change in Status MDS assessment, dated 11/17/23, indicated the resident's cognition was severely impaired. The nurse's note, dated 5/12/23 at 9:21 a.m., indicated the nurse was alerted that the resident was on his knees next to the bathroom door. The resident had a laceration to his forehead with complaints of right knee pain. Pressure and ice were applied to the area, and EMS was called. The record lacked documentation of a signed Transfer/Discharge form provided to the resident or representative. The nurse's note, dated 8/21/23 at 4:26 a.m., indicated EMS arrived at the facility and the resident was in severe pain. The local hospital did not have an orthopedic physician in house, so the resident was being taken to another hospital. The nurse's note, dated 8/21/23 at 4:40 a.m., indicated EMS had exited the facility with the resident and was transporting the resident to the other hospital. The record lacked documentation of a signed Transfer/Discharge form provided to the resident or representative. The nurse's note, dated 11/26/23 at 4:34 p.m.,			

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	indicated a CNA alerted the nurse that the resident was vomiting. Vital signs were taken, and the resident had a temperature of 100.7 Fahrenheit. The resident had fallen with a head injury yesterday. The resident's pupils were evaluated, and the left pupil was in the twos and the right pupil was six (baseline). The hospice company was made aware of the situation and indicated they would send a nurse to evaluate the resident. The hospice nurse called and indicated she could not make it to the facility to assess the resident within a reasonable amount of time and the doctor gave orders to send the resident to ER to be evaluated and treated. EMS were called and a transport was requested. EMS transported the resident to a local hospital for evaluation and treatment. During an interview on 1/8/24 at 10:12 a.m., RN 1 indicated he sent a CCD sheet, the face sheet, physician's progress notes and the Transfer/Discharge form in a packet when a resident went out to the hospital. They had just started making up the packets to send with residents last year. During an interview on 1/8/23 at 9:25 a.m., the DHS (Director of Health Services) indicated she had no documentation of the Transfer/Discharge for the resident. 5. The record for Resident 272 was reviewed on 1/4/24 at 2:18 p.m. The diagnoses included but were not limited to, arthrodesis status, pulmonary embolism, discitis lumbar region, intervertebral disc displacement lumbar region, spinal stenosis, lumbar region with neurogenic claudication. The nurse's note, dated 10/20/23 at 7:40 a.m., indicated the resident had a change in his			

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	cognitive status. The resident had been up for breakfast, was talking, and went to the toilet. Approximately 15 minutes later, the resident was diaphoretic, had a heart rate in the 150s, and was not responding. 911 was called and the resident was transferred to the hospital. The Admission MDS assessment, dated 10/31/23, indicated the resident was cognitively intact. The record lacked documentation of a signed Transfer/Discharge form provided to the resident or representative. 3.1-12(a)(6)(A)			
F 0625 SS=E Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.			

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	§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility failed to ensure 5 of 6 residents or responsible parties were provided written notice of and signed the facility's bed hold policy upon transfer to an acute care facility. (Residents 9, 67, 21, 12, and 272) Findings include: 1. A nurse's note, dated 10/21/23 at 1:55 p.m., indicated Resident 9 was observed to have a change in condition with increased confusion and lethargy. The physician was notified and new orders were received to transfer the resident to the hospital emergency room. The family was made aware of the transfer. Documentation lacked the resident or the responsible party were given the facility's bed hold policy, the policy was explained to them, or had them sign a copy of it. The resident's diagnoses included, but were not limited to, altered mental status, hypertensive heart disease with heart failure, acute systolic (congestive) heart failure, fluid overload, and acute pulmonary edema. The Admission Minimum Data Set (MDS) assessment, dated 10/25/23, indicated the resident's cognition was severely impaired.	F 0625	Past non compliance granted on 12.4 2023	01/29/2024

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	2. The nurse's note, dated 10/6/23 at 8:01 p.m., indicated Resident 67 had become very aggressive and combative during the shift with multiple requests to go home. The physician was notified and gave new orders for the resident to be sent to a hospital for evaluation and treatment. Documentation lacked to indicated the resident or the responsible party were given the facility's bed hold policy, the policy was explained to them, or had them sign a copy of it. The resident's diagnoses included, but were not limited to, generalized muscle weakness, abnormalities of gait and mobility, other symptoms and signs involving cognitive functions and awareness, and Alzheimer's disease. The Admission MDS assessment, dated 9/26/23, indicated the resident's cognition was severely impaired. 3. A nurse's note, dated 10/11/23 at 11:41 p.m., indicated Resident 21's X-ray results showed an acute left intertrochanteric hip fracture. The physician was notified and gave an order to send the resident to the hospital. Family was called and informed. Documentation lacked to indicate the resident or the responsible party were given the facility's bed hold policy, the policy was explained to them, or had them sign a copy of it. The resident's diagnoses included, but were not limited to, displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, hemiplegia and hemiparesis following cerebral infarction affecting			

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	left non-dominant side, type 2 diabetes mellitus with diabetic neuropathy, unspecified, age-related osteoporosis, unspecified fall, and other abnormalities of gait and mobility. The Quarterly MDS assessment, dated 8/18/23, indicated the resident was alert and oriented. During an interview on 1/5/24 at 1:30 p.m., LPN (Licensed Practical Nurse) 2 indicated a copy of the facility's bed hold policy was put into the packet and sent with the resident to the hospital. She did not give the resident or the family a copy of the Bed Hold policy or have them sign it. 4. a. The nurse's note, dated 5/12/23 at 9:21 a.m., indicated the nurse was alerted that Resident 12 was on his knees next to the bathroom door. The resident had a laceration to his forehead with complaints of right knee pain. Pressure and ice were applied to the area and EMS was called. b. The nurse's note, dated 8/21/23 at 4:40 a.m., indicated EMS had exited the facility with the resident and was transporting the resident to the other hospital. c. The nurse's note, dated 11/26/23 at 4:34 p.m., indicated a CNA alerted the nurse that the resident was vomiting. Vital signs were taken, and the resident had a temperature of 100.7 Fahrenheit. The resident had fallen with a head injury yesterday. The resident's pupils were evaluated, and the left pupil was in the twos and the right pupil was six (baseline). The hospice company was made aware of the situation and indicated they would send a nurse to evaluate the resident. The hospice nurse called and indicated she could not make it to the facility to assess the resident within a reasonable amount of time and the doctor gave orders to send the resident to ER to be			

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HAMPTON OAKS HEALTH CAMPUS	966 N WILSON RD SCOTTSBURG, IN 47170

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	evaluated and treated. EMS were called and a transport was requested. EMS transported the resident to a local hospital for evaluation and treatment. The record lacked documentation of a signed Bed Hold form provided to the resident or the resident's representative for all the following resident transfer dates: 5/12, 8/21, and 11/26/23. The record for Resident 12 was reviewed on 1/4/24 at 10:35 a.m. The diagnoses included, but were not limited to, senile degeneration of brain, cardiomegaly, chronic kidney disease, Alzheimer's disease with late onset, dementia, disorientation, osteoarthritis, fall, palliative care, sepsis, dementia with agitation, encephalopathy, history of falling, fracture of the neck of left femur. The Significant Change in Status MDS assessment, dated 11/17/23, indicated the resident was severely cognitively impaired. During an interview on 1/8/23 at 9:25 a.m., the DHS provided a copy of the Bed Hold Notification form. There was no signature of receipt of the document. There was no documentation of the resident or representative receiving a copy of the Bed Hold Notification. During an interview on 1/8/24 at 10:12 a.m., RN 1 indicated he sent a CCD (continuity of care document) sheet and the Bed Hold policy, the face sheet, physician's progress notes and the Transfer/Discharge form in a packet when a resident went out to the hospital. They had just started making up the packets to send with residents last year. During an interview on 1/8/23 at 9:25 a.m., the			

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	DON indicated she had no documentation of the Bed Hold for the resident. 5. The nurse's note, dated 10/20/23 at 7:40 a.m., indicated Resident 272 had a change in his cognitive status. The resident had been up for breakfast, was talking, and went to toilet. Approximately 15 minutes later, the resident was diaphoretic, had a heart rate in the 150s, and was not responding. Emergency 911 was called and the resident was transferred to the hospital. The resident's diagnoses included, but were not limited to, arthrodesis status; pulmonary embolism; and discitis lumbar region, intervertebral disc displacement lumbar region, spinal stenosis, lumbar region with neurogenic claudication. The Admission MDS assessment, dated 10/31/23, indicated the resident was cognitively intact. The DHS provided a copy of the facility's Bed Hold Notification form for Resident 272 on 1/5/24 at 2:45 p.m. There was no documentation or signature by the resident or representative having received a copy of the Bed Hold Notification. During an interview on 1/5/24 at 1:35 p.m., RN 3 indicated the bed hold was signed by the resident if able or the family if they were present and given a copy. If the resident was not able to sign and no family was present, then just 2 nurses would sign the bed hold as witnesses. During an interview on 1/5/24 at 1:36 p.m., RN 4 indicated the bed hold policy would be signed by 2 nurses only if the resident was unable to sign or no family were present.			

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	During an interview on 1/5/24 at 1:40 p.m., LPN 5 indicated she had the resident if able or the family sign the bed hold policy when transferred to the hospital. During an interview on 1/5/24 at 1:53 p.m., the Regional Director of Clinical Operations indicated she had the DHS (Director of Health Services) implement an action plan on what to send with the resident to appointments and the hospital and what to have the resident or family sign. During interview on 1/5/24 also at 1:53 p.m., the DHS indicated she developed an action plan on 12/4/23. She had inserviced the nurses, on 12/5/23, related to the paperwork needed to accompany the resident when going to appointments or the hospital. This included having the resident or family sign the bed hold policy. She then did audits on those residents who went out to the hospital after 12/4/23 for compliance. The facility's current policy on Guidelines for Transfer and Discharge (Including AMA) included, but was not limited to, "...Procedures: 5. Notice of Bed-Hold Policy and Readmission:...b. Before the facility transfers a resident to a hospital...Nursing staff or other designated staff member should provide written information to the resident and a family member or legal representative of the bed-hold and admission policies. c. In cases of emergency transfers, the notice of the bed-hold policy should be provided to the resident or resident's representative within 24 hours of the transfer...d. Social Services should review the documentation the following business day to assure written information was provided to the resident and a family member or legal representative of the bed-hold and admission policies. Notification of bed-Hold Policy and			

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	Readmission should be provided via certified mail in the event notification was not provided as part of the discharge process." The facility's current Bed Hold Policy - Policies and Procedures Revenue Billing and Collections included, but was not limited to, "Policy: The campus will properly inform residents in advance or their option to make bed-hold payments as well as the amount of the facility's charge to hold a bed...Purpose: To establish a policy and procedure following a state and federal guidelines as iot pertains to resident notification and billing procedures for hospital leave therapeutic leave bed-hold..." The Past noncompliance began on 12/4/23 and the deficient practice corrected by 1/4/24 after the facility implemented a systemic plan that included the following actions: The facility completed nurse education on the discharge process and Bed-Hold policy (12/5/23) and all residents transferred to the hospital after 12/4/23 were audited to ensure 100% compliance on transfers/discharges to the hospital. 3.1-12(a)(25) 3.1-12(a)(26)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to			

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	applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner for 4 of 4 observations. This deficient practice had the potential to affect all 65 residents currently residing at the facility. Findings include: 1. During the initial tour of the kitchen on 1/2/24 between 9:10 a.m. and 9:40 a.m. while accompanied by the Director of Food Service, the following concerns were observed: - The shelf below the steamer had a dinner plate size brown puddle on it along with tan food particles. - The top of the dishwasher had a heavy soil of brown and yellow food crumbs and grease. - The grill slats had a heavy coat of dried black crust on them with black crumbs on the tray in front of the grill. The Director of Food Service indicated at this time that the cooks scraped it off after each time they used it. - The left side of the convection oven next to the grill had a heavy coat of yellow/brown grease and food particles.	F 0812	**1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** **No adverse effects occurred to residents due to alleged deficient practice.** **2 How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** **All residents have the potential to be affected by the alleged deficient practice.** **Director of food services/Designee will in-service all dietary staff on cleaning schedule and sanitation expectations.** **3 What measures will be put into place, and what systemic changes will be made to ensure the deficient practice**	01/29/2024

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	- The right side of the stove next to the grill and the left side of the stove next to the fryer had a heavy coat of yellow and brown grease and food particles. - The entire length of the metal strip of the range hood near the ceiling had a heavy coat of brown grease with gray dust stuck to it. - The shelf under the main prep counter in front of the stove had various small piece of food particles and spots on it. - The Walk-in fridge 2 condenser fan covers, the area surrounding the fans and the ceiling of the walk in had a 2 foot wide section that ran the entire length of the unit with a moderate coating of gray greasy dust. The entire length of silver electric cord to the light fixture above the entrance door was coated with a moderate amount of gray dust. The fans were running at this time and there were open boxes of various produce items on the shelves. - The fryer had a moderate amount of brown food particles in the oil. - The stove burners had a build up of brown food particles on them. 2. During the lunch meal observation in the kitchen on 1/2/24 between 11:20 a.m. and 12: 30 p.m., the following concerns were observed: - The same issues identified at 9:10 a.m. remained. - Inside the sandwich station, there was a moderate amount of brown and yellow food particles on the bottom shelf and the entire outside of the unit had streaks and brown food particles on it. - The toaster unit - there were brown crumbs on the top rack and a heavy build-up of black debris under the 2 chains that propelled the racks was able to be scraped with a paper towel. - Under the fryer and steamer was a piece of		**does not recur?** **As a measure of ongoing compliance, DFS/Designee will monitor daily and weekly cleaning both visually and by cleaning lists. DFS/Designee will conduct sanitation audit 5 X a week x 4 weeks, then twice weekly x 2 months, then weekly x 3 months.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** **As a quality measure, the Executive Director/Designee will review any findings and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.**	

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	frozen fish and fried fish was observed on the steam table for lunch. 3. During a kitchen observation on 1/4/24 between 10:55 a.m. and 11:30 a.m., the following concerns were observed: - The same concerns identified on 1/2/24 at 9:10 a.m. and 11:10 a.m. remained. - The grill grates had a heavy build-up of black debris on them and there were black and yellow food particles in the tray in front of the grates. The Assistant Dietary Manager indicated at this time that the grill was last used the previous evening. - Although the brown puddle on the shelf below the steamer was gone, there was still multiple dried spots. - The piece of fish remained under the fryer along with 4 french fries under the fryer and stove floor. - The toaster remained with a black substance under the chains and a heavy build up of bread crumbs on the bottom ledge and under the toaster. - The front ledge of the range hood remained with heavy yellow/brown grease and the section of the hood below the filters between the stove, grill, and convection oven had a heavy coating of yellow/brown grease on it. - Although a Dietary Aide was observed sweeping the floor under the shelving racks, a creamer and plastic lid remained on the floor under the cereal and microwave counter. 4. During a kitchen observation on 1/8/24 at 1:10 p.m. with the Director and Assistant Director of Food Services, the following concerns were identified: - The same issues identified on 1/2/24 at 9:10 a.m.			

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	and 11:10 a.m. and on 1/4/24 at 10:55 a.m. remained. - The shelf under the steamer had multiple dried spots on it. - The sandwich station inside bottom cabinet remained the same. When the cover was lifted, there was yellow and brown food debris along the outside edge of the wells with wilted lettuce inside one of the wells. - The front ledge hood remains with heavy yellow/brown grease, the section of the hood below the filters between the stove, grill and convection oven remains with a heavy coating of yellow/brown grease. - The tops of the flour, sugar and bread crumb bins were soiled with a white powdery substance and the outside of the bins had dirt streaks on them. - The front of the steam table had dried water streaks down the entire front. - The outside of the prep sink had a heavy soil of brown/black dried food particles. - The wall behind the stove, grill and convection oven had a heavy build up of grease and food particles. - The fries and the piece of fish were now gone. During an interview on 1/8/24 at 1:23 p.m., the Assistant Director of Food Services indicated that Maintenance had an outside company who came in to clean the hood, but did not know how often or when the last time the company came in. Maintenance was responsible for cleaning the fans in the walk-in refrigerator. During an interview on 1/8/24 at 1:25 p.m., the Director of Food Services indicated the afternoon cooks and staff had more time to do the cleaning, some of the things, like the stove burners were left to them to do instead of the morning cooks. All			

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	the staff should be cleaning the sides of the stove and the convection oven. The cooks were supposed to strain the food crumbs from the oil after using it. During an interview on 1/8/24 at 1:30 p.m., the Maintenance Director indicated he cleaned the walk-in refrigerator fans every six months at the same time as the outside company came in to clean the range hood. They were due to come in this month and that he would take care of cleaning the fans when they came in. The receipt from the outside company indicated they were last in the facility on 7/9/23. On 1/9/24 at 9:00 a.m., the Director of Food Services presented a copy of the as-completed cleaning schedules, dated 12/31/23 to 1/6/24, for the cooks and dietary aides. Review of the schedules indicated the following tasks were signed off as being completed each day during this time period: a. AM Cook Cleaning Schedule: - Steamer - wipe down. - Fryer - wiped down and strained. - Charbroiler - grates clean, wiped down including hose. - Charbroiler Drip Tray emptied and relined with foil. - Toaster - clean and free of crumbs. - Convection ovens, including hose. - Back wall behind equipment. - Remove and clean range top burner covers. - Prep table clean - including bottom shelf. - Sweep and Mop floor - including under equipment. b. AM Aide Cleaning Schedule: - Dishwasher cleaned.			

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	c. PM Cook Cleaning Schedule: - Steamer - wipe down. - Fryer - wiped down and strained. - Charbroiler - grates clean, wiped down including hose. - Charbroiler Drip Tray emptied and relined with foil. - Convection ovens, including hose. - Back wall behind equipment. - Remove and clean range top burner covers. - Prep table clean - including bottom shelf. - Sweep and Mop floor - including under equipment. 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: January 2, 3, 4, 5, 8, and 9, 2024 Facility number: 004902 Residential Census: 22 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on January 16, 2024.	R 0000	On January 9, 2024, Hampton Oaks Health Campus 966 North Wilson Road Scottsburg, Indiana 47170 Survey Event ID 665Q11. The submission of this 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 its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the	

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			requirements of participation for comprehensive health care facilities (for Title 18/19 programs). Attached you will find our Plan of Correction for Hampton Oaks Health Campus for our annual survey conducted on September 23, 2014. We initiated immediate interventions 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. Sincerely, Brandy Royalty, Executive Director.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner for 4 of 4 observations. This deficient practice had the potential to affect all 22 Residential residents currently residing at the facility. Findings include: 1. During the initial tour of the kitchen on 1/2/24 between 9:10 a.m. and 9:40 a.m. while accompanied by the Director of Food Service, the following concerns were observed:	R 0273	**1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** **No adverse effects occurred to residents due to alleged deficient practice.** **2 How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** **All residents have the**	01/29/2024

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	- The shelf below the steamer had a dinner plate size brown puddle on it along with tan food particles. - The top of the dishwasher had a heavy soil of brown and yellow food crumbs and grease. - The grill slats had a heavy coat of dried black crust on them with black crumbs on the tray in front of the grill. The Director of Food Service indicated at this time that the cooks scraped it off after each time they used it. - The left side of the convection oven next to the grill had a heavy coat of yellow/brown grease and food particles. - The right side of the stove next to the grill and the left side of the stove next to the fryer had a heavy coat of yellow and brown grease and food particles. - The entire length of the metal strip of the range hood near the ceiling had a heavy coat of brown grease with gray dust stuck to it. - The shelf under the main prep counter in front of the stove had various small piece of food particles and spots on it. - The Walk-in fridge 2 condenser fan covers, the area surrounding the fans and the ceiling of the walk in had a 2 foot wide section that ran the entire length of the unit with a moderate coating of gray greasy dust. The entire length of silver electric cord to the light fixture above the entrance door was coated with a moderate amount of gray dust. The fans were running at this time and there were open boxes of various produce items on the shelves. - The fryer had a moderate amount of brown food particles in the oil. - The stove burners had a build up of brown food particles on them. 2. During the lunch meal observation in the kitchen on 1/2/24 between 11:20 a.m. and 12: 30		**potential to be affected by the alleged deficient practice.** **Director of food services/Designee will in-service all dietary staff on cleaning schedule and sanitation expectations.** **3 What measures will be put into place, and what systemic changes will be made to ensure the deficient practice does not recur?** **As a measure of ongoing compliance, DFS/Designee will monitor daily and weekly cleaning both visually and by cleaning lists. DFS/Designee will conduct sanitation audit 5x a week x 4 weeks, then twice weekly x 2 months, then weekly x 3 months.** **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** **As a quality measure, the Executive Director/Designee will review any findings and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.**	

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	p.m., the following concerns were observed: - The same issues identified at 9:10 a.m. remained. - Inside the sandwich station, there was a moderate amount of brown and yellow food particles on the bottom shelf and the entire outside of the unit had streaks and brown food particles on it. - The toaster unit - there were brown crumbs on the top rack and a heavy build-up of black debris under the 2 chains that propelled the racks was able to be scraped with a paper towel. - Under the fryer and steamer was a piece of frozen fish and fried fish was observed on the steam table for lunch. 3. During a kitchen observation on 1/4/24 between 10:55 a.m. and 11:30 a.m., the following concerns were observed: - The same concerns identified on 1/2/24 at 9:10 a.m. and 11:10 a.m. remained. - The grill grates had a heavy build-up of black debris on them and there were black and yellow food particles in the tray in front of the grates. The Assistant Dietary Manager indicated at this time that the grill was last used the previous evening. - Although the brown puddle on the shelf below the steamer was gone, there was still multiple dried spots. - The piece of fish remained under the fryer along with 4 french fries under the fryer and stove floor. - The toaster remained with a black substance under the chains and a heavy build up of bread crumbs on the bottom ledge and under the toaster. - The front ledge of the range hood remained with heavy yellow/brown grease and the section of the hood below the filters between the stove, grill,			

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	155753	A. BUILDING 00 B. WING	01/09/2024

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

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	and convection oven had a heavy coating of yellow/brown grease on it. - Although a Dietary Aide was observed sweeping the floor under the shelving racks, a creamer and plastic lid remained on the floor under the cereal and microwave counter. 4. During a kitchen observation on 1/8/24 at 1:10 p.m. with the Director and Assistant Director of Food Services, the following concerns were identified: - The same issues identified on 1/2/24 at 9:10 a.m. and 11:10 a.m. and on 1/4/24 at 10:55 a.m. remained. - The shelf under the steamer had multiple dried spots on it. - The sandwich station inside bottom cabinet remained the same. When the cover was lifted, there was yellow and brown food debris along the outside edge of the wells with wilted lettuce inside one of the wells. - The front ledge hood remains with heavy yellow/brown grease, the section of the hood below the filters between the stove, grill and convection oven remains with a heavy coating of yellow/brown grease. - The tops of the flour, sugar and bread crumb bins were soiled with a white powdery substance and the outside of the bins had dirt streaks on them. - The front of the steam table had dried water streaks down the entire front. - The outside of the prep sink had a heavy soil of brown/black dried food particles. - The wall behind the stove, grill and convection oven had a heavy build up of grease and food particles. - The fries and the piece of fish were now gone.			

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	155753	A. BUILDING 00 B. WING	01/09/2024

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HAMPTON OAKS HEALTH CAMPUS	966 N WILSON RD SCOTTSBURG, IN 47170

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	During an interview on 1/8/24 at 1:23 p.m., the Assistant Director of Food Services indicated that Maintenance had an outside company who came in to clean the hood, but did not know how often or when the last time the company came in. Maintenance was responsible for cleaning the fans in the walk-in refrigerator. During an interview on 1/8/24 at 1:25 p.m., the Director of Food Services indicated the afternoon cooks and staff had more time to do the cleaning, some of the things, like the stove burners were left to them to do instead of the morning cooks. All the staff should be cleaning the sides of the stove and the convection oven. The cooks were supposed to strain the food crumbs from the oil after using it. During an interview on 1/8/24 at 1:30 p.m., the Maintenance Director indicated he cleaned the walk-in refrigerator fans every six months at the same time as the outside company came in to clean the range hood. They were due to come in this month and that he would take care of cleaning the fans when they came in. The receipt from the outside company indicated they were last in the facility on 7/9/23. On 1/9/24 at 9:00 a.m., the Director of Food Services presented a copy of the as-completed cleaning schedules, dated 12/31/23 to 1/6/24, for the cooks and dietary aides. Review of the schedules indicated the following tasks were signed off as being completed each day during this time period: a. AM Cook Cleaning Schedule: - Steamer - wipe down. - Fryer - wiped down and strained. - Charbroiler - grates clean, wiped down including			

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	hose. - Charbroiler Drip Tray emptied and relined with foil. - Toaster - clean and free of crumbs. - Convection ovens, including hose. - Back wall behind equipment. - Remove and clean range top burner covers. - Prep table clean - including bottom shelf. - Sweep and Mop floor - including under equipment. b. AM Aide Cleaning Schedule: - Dishwasher cleaned. c. PM Cook Cleaning Schedule: - Steamer - wipe down. - Fryer - wiped down and strained. - Charbroiler - grates clean, wiped down including hose. - Charbroiler Drip Tray emptied and relined with foil. - Convection ovens, including hose. - Back wall behind equipment. - Remove and clean range top burner covers. - Prep table clean - including bottom shelf. - Sweep and Mop floor - including under equipment.			