STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155753	B. WI	NG		01/09/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				VILSON RD		
HAMPTC	N OAKS HEALTH	CAMPUS			SBURG, IN 47170		
(X4) ID	SUMMARY S	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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00			l				
		D. C. C. L. L. C. L.	F 00)00	On January 9, 2024, Hampton		
		Recertification and State			Oaks Health Campus 966 Nor		
	-	This visit included a State			Wilson Road Scottsburg, India		
	Residential Licensu	re survey.			47170 Survey Event ID 665Q1		
	Curren detect Icere	ory 2 2 4 5 8 and 0 2024			The submission of this Plan of		
	Survey dates: Janua	ry 2, 3, 4, 5, 8, and 9, 2024			Correction does not indicate a	H	
	Facility number: 00	4902			admission by Hampton Oaks Health Campus that the finding	ne	
	Provider number: 1:				and allegations contained here	•	
	AIM number: 2008				are accurate and true	511 I	
	7 mivi number. 2000	13130			representations of the quality of	nf.	
	Census Bed Type:				care and services provided to		
	SNF/NF: 44				residents of Hampton Oaks He		
	SNF: 21				Campus. This facility recognize		
	Residential: 22				its obligation to provide legally		
	Total: 87				medically necessary care and		
					services to its residents in an		
	Census Payor Type:	:			economic and efficient manne	r.	
	Medicare: 17				The facility hereby maintains it		
	Medicaid: 32				in substantial compliance with		
	Other: 16				requirements of participation fo		
	Total: 65				comprehensive health care		
					facilities (for Title 18/19		
		reflect State Findings cited in			programs). Attached you will t	find	
	accordance with 410	0 IAC 16.2-3.1.			our Plan of Correction for Ham	pton	
					Oaks Health Campus for our		
	Quality review com	pleted on January 16, 2024.			annual survey conducted on		
					September 23, 2014. We initia	ated	
					immediate interventions when		
					concerns were identified on th		
					date. We respectfully request		
					paper review for this plan of		
					correction. If you need any		
					information or paperwork, plea		
					do not hesitate to contact us a		
					(812)752-2694. Sincerely, Bra	andy	
					Royalty, Executive Director.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155753	B. W	ING		01/09/	/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 966 N WILSON RD SCOTTSBURG, IN 47170			
(VA) ID	CLIMMADY	ET A TEMENT OF DEFICIENCIE	1	ID			(VE)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
			+	ind			DATE
F 0623	483.15(c)(3)-(6)(8)						
SS=E	Notice Requireme						
Bldg. 00	Transfer/Discharg						
	- ',','	ce before transfer.					
	<u> </u>	ansfers or discharges a					
	resident, the facilit	-					
		ent and the resident's					
		of the transfer or discharge or the move in writing and in					
		anner they understand. The					
		a copy of the notice to a					
	-	he Office of the State					
	Long-Term Care (
	_	sons for the transfer or					
	` '	esident's medical record in					
	•	aragraph (c)(2) of this					
	section; and	a. ag. ap (e)(=) e. ae					
		notice the items described					
	in paragraph (c)(5						
	1 0 1 ()(,					
	§483.15(c)(4) Tim	ing of the notice.					
	(i) Except as spec	ified in paragraphs (c)(4)(ii)					
	and (c)(8) of this s	ection, the notice of					
	transfer or dischar	ge required under this					
	section must be m	ade by the facility at least					
	30 days before the	e resident is transferred or					
	discharged.						
	(ii) Notice must be						
	•	transfer or discharge when-					
	, ,	ndividuals in the facility					
	_	ered under paragraph (c)(1)					
	(i)(C) of this section						
	, ,	ndividuals in the facility					
	_	ered, under paragraph (c)(1)					
	(i)(D) of this section						
		health improves sufficiently					
		mediate transfer or					
		paragraph (c)(1)(i)(B) of this					
	section;						
	(ロ) An immediate	transfer or discharge is	- 1				İ

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155753	B. W	ING		01/09/	2024
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	2		1	VILSON RD		
LAMOTO	ON OAKS HEALTH	CAMBLIS			SBURG, IN 47170		
HAIVIFIC	IN OAKS HEALTH	CAIVIFUS		30011	3BURG, IN 47 170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	required by the re	sident's urgent medical					
	needs, under para	agraph (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						
		cified in paragraph (c)(3) of					
		include the following:					
	, ,	transfer or discharge;					
	` '	ate of transfer or discharge;					
	1 ' '	o which the resident is					
	transferred or disc	-					
	` '	f the resident's appeal					
	-	ne name, address (mailing					
		elephone number of the					
	1 -	ves such requests; and					
		w to obtain an appeal form					
		completing the form and					
		peal hearing request;					
		dress (mailing and email)					
	-	mber of the Office of the					
	_	Care Ombudsman;					
	1 ' '	cility residents with					
		evelopmental disabilities or					
		the mailing and email					
		hone number of the agency					
	1	e protection and advocacy					
	established under	developmental disabilities					
		sabilities Assistance and					
		of 2000 (Pub. L. 106-402,					
	I -	.C. 15001 et seq.); and					
		acility residents with a					
	` <i>'</i>	r related disabilities, the					
		address and telephone					
	_	ency responsible for the					
		vocacy of individuals with a					
	I -	stablished under the					
		vocacy for Mentally III					
	i Totodion and Ad	vocacy for Michially III					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/09/2024	
	PROVIDER OR SUPPLIER		966 N	ADDRESS, CITY, STATE, ZIP COD WILSON RD TSBURG, IN 47170	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	If the information is to effecting the trafacility must update notice as soon as updated information. §483.15(c)(8) Notice to the case of facility who is the administ provide written not impending closure. Agency, the Office Care Ombudsmar and the resident residen	upon transfer to an acute care 9, 67, 21, 12, and 272) esident 9 was reviewed on The diagnoses included, but altered mental status, disease with heart failure, estive) heart failure, fluid	F 0623	1 What corrective action to be accomplished for those residents found to have been affected by the deficient practice? No adverse effects occurred residents due to alleged deficient practices. 2 How other residents have the potential to be affected by the same deficient practice be identified and what corrective action(s)will be taken? All residents who transfer of discharge have the potential be affected by the alleged deficient practice. All nursing staff who transfer patients	en d to ving by will or ol to

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STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155753	B. W	ING		01/09/2024	
NAME OF T	ADOLUDED OF CURPY YES		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIEF	<			VILSON RD		
HAMPTO	N OAKS HEALTH	CAMPUS		SCOTT	SBURG, IN 47170		
(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		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		ed 10/21/23 at 1:55 p.m.,			in-serviced on the transfer		
		ent had a change in condition			policy by DHS.		
		fusion and lethargy; Labored			3 What measures will be pu	ıt	
	-	s of air, and flushed skin. Her			into place, and what systemic		
	colostomy was observed to have bright red tinged				changes will be made to ensu		
	substances with a foul odor. The resident was				the deficient practice does not		
	unable to answer questions regarding pain or				recur?		
	discomfort. The physician was notified and new				As a measure of ongoing		
		ed to transfer the resident to the			compliance, DHS or designe	e	
		room. The family was made			will audit all transferred or	_	
	aware of the transfe	er.			discharged residents in CCN	1	
	D 44' 1.1				for proper notification of		
	Documentation lacked to indicate the resident or the responsible party were given written notice				transfer or discharge to		
		•			resident or responsible party		
	-	transfer to the hospital, of the			5x/week x 4 weeks, 3/week x	3	
	-	esident to be transferred to the			months, and 1x/week x 2		
	nospital or which h	ospital she was going to.			months.		
	2 Th 1 f D	:14 67 1			4 How the corrective		
		esident 67 was reviewed on			action(s) will be monitored to		
	-	The diagnoses included, but pain in left shoulder,			ensure the deficient practice		
		weakness, abnormalities of			will not recur?		
	-	other symptoms and signs			As a quality measure, the		
	-	functions and awareness, and			Executive Director (ED) or		
	Alzheimer's disease				designee will review any findings and corrective action	.n	
	Anzheimei s discase	. .			at least quarterly in the camp		
	The Admission MF	OS assessment, dated 9/26/23,			Quality Assurance Performa		
		ent's cognition was severely			Improvement meetings. The		
	impaired.	nes cognition was severely			plan will be reviewed and		
	impanou.				updated as warranted and w	iii	
	The nurse's note do	ated 10/6/23 at 8:01 p.m.,			continue until 100% complia		
		ent had become very			is maintained.		
		bative during the shift with					
		go home. All efforts at					
		After the nurse then sat with the					
		time to vent her feelings and					
	_	e went back to the nurse's					
		amily to come in. The nurse					
		oise from the resident's room					
		ent laying on her back. She					
		, 6					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	
		155753	B. WING			01/09/	/2024
	PROVIDER OR SUPPLIER		96	66 N V	ADDRESS, CITY, STATE, ZIP COD VILSON RD SBURG, IN 47170	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION		\G	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	then rolled to her si	de with her head resting on the					
	bed frame and yelle	ed to go home. Upon					
	assessment, the resi	dent indicated her back was					
	hurting and began v	omiting on herself. She					
	further indicated sh	e was unable to have the					
	nurse touch her bac	k and began having labored					
	breathing and feeling	ng dizzy. While another nurse					
		the resident, the resident					
		me and was combative. The					
		ied and gave new orders for					
		ent to a special hospital for					
		ment. While EMS (Emergency					
	Medical Services) was evaluating and assisting						
		tretcher, she vomited a third					
	time. Family was no	otified of the event.					
	Documentation lack	xed to indicate the resident or					
		y were given written notice					
		hospital, of the reasoning for					
	the resident to be tra	ansferred to the hospital or					
	which hospital she	was going to.					
	Dymin a an interview	on 1/5/24 at 1:53 p.m., the					
	_	of Clinical Operations indicated					
	-	ocate a copy of the Notice of					
	Transfer/Discharge						
	Transfer, Discharge	101 1130140Ht 0/1					
	3. The record for Re	esident 21 was reviewed on					
		The diagnoses included, but					
		displaced intertrochanteric					
	fracture of left femu	ır, subsequent encounter for					
		routine healing, hemiplegia					
	and hemiparesis fol	lowing cerebral infarction					
	affecting left non-d	ominant side, type 2 diabetes					
	mellitus with diabet	tic neuropathy, unspecified,					
	age-related osteopo	rosis, unspecified fall, and					
	other abnormalities	of gait and mobility.					
		S assessment, dated 8/18/23,					
	indicated the reside	nt was alert and oriented.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/09/2024	
	PROVIDER OR SUPPLIEF		966 N	ADDRESS, CITY, STATE, ZIP COD WILSON RD ISBURG, IN 47170	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRODEFICIENCY)	O BE COMPLETION
	indicated that while bathroom in order to by the CNA (Certif left leg gave out and unable to hold the resident was assiste complain of left hip family and manager orders were receive hip and knee and condition of left hip and knee and condition of left hip family and manager orders were receive hip and knee and condition of left hip and knee and condition of left hip family and knee and condition of left hip family and knee and condition of left hip and left	d 10/11/23 at 11:41 p.m., results showed an acute left of fracture. Physician was norder to send the resident to was called and informed. Red to indicate the resident or y were given written notice hospital, of the reasoning for ansferred to the hospital or was going to. You on 1/5/24 at 1:30 p.m. with ctical Nurse) 2, she indicated a transfer form, list of the continuity of care form of the Notice of was put into the packet and int to the hospital. She did not the family a copy of the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPI	
		155753	B. W	ING		01/09	/2024
NAME OF P	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
					WILSON RD		
НАМРГС	N OAKS HEALTH	CAMPUS		SCOTT	SBURG, IN 47170		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		esident 12 was reviewed on		TAG	DEFICIENCE		DATE
		i. The diagnoses included, but					
	were not limited to, senile degeneration of brain,						
		nic kidney disease stage,					
		e with late onset, dementia,					
		oarthritis, fall, palliative care,					
		ith agitation, encephalopathy,					
	-	racture of the neck of left femur.					
	The Significant Cha	ange 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 no	ext to the bathroom door. The					
	resident had a lacer	ration to his forehead with					
	complaints of right	knee pain. Pressure and ice					
	were applied to the	area, and EMS was called.					
	The record lacked of	documentation of a signed					
		form provided to the resident					
	or representative.	1					
	•						
	· ·	ated 8/21/23 at 4:26 a.m.,					
		ved at the facility and the					
		ere pain. The local hospital did					
	_	edic physician in house, so the					
	resident was being	taken to another hospital.					
	The nurse's note do	ated 8/21/23 at 4:40 a.m.,					
		exited the facility with the					
		ansporting the resident to the					
	other hospital.	anoporting the resident to the					
	The record looked a	documentation of a signed					
		form provided to the resident					
	or representative.	Torm provided to the resident					
	or representative.						
	The nurse's note da	ated 11/26/23 at 4:34 n m					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/09/2024		
	PROVIDER OR SUPPLIER		966 N V	ADDRESS, CITY, STATE, ZIP COD WILSON RD SBURG, IN 47170	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL DESCRIPTION OF THE PROPERTY OF THE PROP	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION
TAG	indicated a CNA ald resident was vomiting the resident had a term and the left pupil was pupil was six (basel was made aware of they would send a make it to the fawithin a reasonable gave orders to send evaluated and treate transport was requeresident to a local hat treatment. During an interview indicated he sent a comply sician's progress. Transfer/Discharge resident went out to started making up the residents last year. During an interview of the progress of the progre	erted the nurse that the ng. Vital signs were taken, and emperature of 100.7 Fahrenheit. Hen with a head injury dent's pupils were evaluated, as in the twos and the right line). The hospice company the situation and indicated nurse to evaluate the resident. He resident amount of time and the doctor the resident to ER to be led. EMS were called and a sted. EMS transported the ospital for evaluation and You 1/8/24 at 10:12 a.m., RN 1 CCD sheet, the face sheet, as notes and the form in a packet when a steh hospital. They had just the packets to send with You 1/8/23 at 9:25 a.m., the fealth Services) indicated she can of the Transfer/Discharge esident 272 was reviewed on The diagnoses included but arthrodesis status, pulmonary umbar region, intervertebral umbar region, spinal stenosis, neurogenic claudication. Atted 10/20/23 at 7:40 a.m., and had a change in his	TAG	DEFICIT 1		DATE

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2024	
	PROVIDER OR SUPPLIER			966 N W	DDRESS, CITY, STATE, ZIP COD VILSON RD SBURG, IN 47170		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
F 0625 SS=E Bldg. 00	cognitive status. The breakfast, was talkin Approximately 15 n diaphoretic, had a h not responding. 911 was transferred to the The Admission MD indicated the resident The record lacked described a transfer/Discharge or representative. 3.1-12(a)(6)(A) 483.15(d)(1)(2) Notice of Bed Hold §483.15(d) Notice return- §483.15(d)(1) Notinursing facility transpiration to the representative tha (i) The duration of any, during which return and resume facility; (ii) The reserve be state plan, under § any; (iii) The nursing fabed-hold periods, with paragraph (e) permitting a reside	S assessment, dated 10/31/23, and was cognitively intact. Cocumentation of a signed form provided to the resident Description of bed-hold policy and Description of bed-hold policy, if the resident or resident to permitted to be residence in the nursing and payment policy in the section of bed-hold policy in the section of bed-hold policy in the section of bed-hold policy in the section, and the payment policy in the section, and the return; and in specified in paragraph (e)		TAG	DEFICIENCY)		DATE

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Event ID:

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Facility ID: 004902

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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	A. BUILDING <u>00</u>			COMPLETED	
		155753	B. W	ING		01/09	/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 966 N WILSON RD SCOTTSBURG, IN 47170					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
	At the time of transhospitalization or the facility must provide resident represent specifies the durated described in parage Based on record revisited to ensure 5 of parties were provide the facility's bed how acute care facility. (272) Findings include: 1. A nurse's note, daindicated Resident Change in condition lethargy. The physicorders were received hospital emergency aware of the transfermous procumentation lack responsible party whold policy, the polihad them sign a copulation. The resident's diagnal limited to, altered meart disease with heart disease with heart disease with heart disease with meart disease with heart dise	seed the resident or the ere given the facility's bed icy was explained to them, or by of it. noses included, but were not mental status, hypertensive leart failure, acute systolic failure, fluid overload, and	F 00	625	Past non compliance granted 12.4 2023	on	01/29/2024	

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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	JILDING	00	COMPL	ETED
		155753	B. W	ING		01/09/	/2024
				CTREET	DDDFGG CITY CTATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
LIAMOTO	NI OAKS HEALTH	CAMPLIC					
HAIVIPTO	ON OAKS HEALTH	CAMPUS		30011	SBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2. The nurse's note,	dated 10/6/23 at 8:01 p.m.,					
	indicated Resident 67 had become very						
	aggressive and com	bative during the shift with					
		go home. The physician was					
	notified and gave no	ew orders for the resident to					
	be sent to a hospital for evaluation and treatment.						
	Documentation lacked to indicated the resident or						
		y were given the facility's bed					
		icy was explained to them, or					
	had them sign a cop	by of it.					
	_	noses included, but were not					
	_	zed muscle weakness,					
	_	it and mobility, other					
		s involving cognitive					
		eness, and Alzheimer's					
	disease.						
		OS assessment, dated 9/26/23,					
		nt's cognition was severely					
	impaired.						
		. 110/11/02 . 11 41					
		ated 10/11/23 at 11:41 p.m.,					
		21's X-ray results showed an					
		anteric hip fracture. The					
		ied and gave an order to send					
		ospital. Family was called and					
	informed.						
	D	and an indicate of the control of					
		ked to indicate the resident or					
		y were given the facility's bed					
		icy was explained to them, or					
	had them sign a cop	by 01 it.					
	The modistrust of	agger in childed but					
		noses included, but were not					
	_	d intertrochanteric fracture of					
		ent encounter for closed					
		e healing, hemiplegia and					
	hemiparesis followi	ing cerebral infarction affecting					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/09/2024	
	PROVIDER OR SUPPLIER		966 N V	ADDRESS, CITY, STATE, ZIP COD WILSON RD 'SBURG, IN 47170	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES OF THE PROPRIES OF	D BE COMPLETION
PREFIX TAG	REGULATORY OR left non-dominant s with diabetic neuro osteoporosis, unspe abnormalities of gai The Quarterly MDS indicated the reside. During an interview (Licensed Practical the facility's bed ho packet and sent with She did not give the of the Bed Hold pol 4. a. The nurse's no indicated the nurse was on his knees ne resident had a lacer complaints of right were applied to the b. The nurse's note, indicated EMS had resident and was tra other hospital. c. The nurse's note, indicated a CNA ale resident was vomiti the resident had a te The resident had fal yesterday. The reside	ide, type 2 diabetes mellitus pathy, unspecified, age-related cified fall, and other	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL)	D BE COMPLETION
	was made aware of they would send a r The hospice nurse c not make it to the fa within a reasonable	the situation and indicated durse to evaluate the resident. Called and indicated she could acility to assess the resident amount of time and the doctor			
	gave orders to send	the resident to ER to be			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/09/2024		
	PROVIDER OR SUPPLIER		966 N V	ADDRESS, CITY, STATE, ZIP COE VILSON RD SBURG, IN 47170)	
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
TAU	evaluated and treate transport was reque resident to a local h treatment.	ed. EMS were called and a sted. EMS transported the ospital for evaluation and	TAG			DATE
	Hold form provided resident's representa resident transfer dat	locumentation of a signed Bed I to the resident or the ative for all the following see: 5/12, 8/21, and 11/26/23.				
	at 10:35 a.m. The d limited to, senile de cardiomegaly, chron disease with late on osteoarthritis, fall, p	dent 12 was reviewed on 1/4/24 iagnoses included, but were not generation of brain, nic kidney disease, Alzheimer's set, dementia, disorientation, balliative care, sepsis, dementia phalopathy, history of falling, of left femur.				
	The Significant Cha assessment, dated 1 was severely cognit	1/17/23, indicated the resident				
	DHS provided a copform. There was no document. There was	on 1/8/23 at 9:25 a.m., the py of the Bed Hold Notification signature of receipt of the as no documentation of the tative receiving a copy of the on.				
	indicated he sent a document) sheet and face sheet, physicia Transfer/Discharge resident went out to	on 1/8/24 at 10:12 a.m., RN 1 CCD (continuity of care d the Bed Hold policy, the n's progress notes and the form in a packet when a the hospital. They had just the packets to send with				
	During an interview	on 1/8/23 at 9:25 a.m., the				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155753	B. W	ING		01/09/	/2024
NAME OF B	ADOLUDED OD GUDDU IER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	C		966 N V	VILSON RD		
HAMPTC	N OAKS HEALTH	CAMPUS		SCOTT	SBURG, IN 47170		
(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 APPROPRIATE DEFICIENCY)		COMPLETION
TAG		had no documentation of the	+	TAG	BEFELENCTY		DATE
	Bed Hold for the re						
	Dea Hola for the fe	Sident.					
	5. The nurse's note,	dated 10/20/23 at 7:40 a.m.,					
	indicated Resident 272 had a change in his						
	cognitive status. Th	e resident had been up for					
	· ·	ng, and went to toilet.					
	* *	minutes later, the resident was					
	-	neart rate in the 150s, and was					
		ergency 911 was called and					
	the resident was trai	nsferred to the hospital.					
	The resident's diagnoses included, but were not						
	_	sis status; pulmonary					
	embolism; and disc						
	intervertebral disc	displacement lumbar region,					
	spinal stenosis, lum	bar region with neurogenic					
	claudication.						
	The Administration MT	05 10/21/22					
		OS assessment, dated 10/31/23, nt was cognitively intact.					
	indicated the reside	nt was cognitively intact.					
	The DHS provided	a copy of the facility's Bed					
		form for Resident 272 on 1/5/24					
	at 2:45 p.m. There v	was no documentation or					
	signature by the res	ident or representative having					
	received a copy of t	the Bed Hold Notification.					
	During an interview	v on 1/5/24 at 1:35 p.m., RN 3					
	-	old was signed by the resident					
		if they were present and given					
		ent was not able to sign and no					
		then just 2 nurses would sign					
	the bed hold as witr						
	Dening a 1 to 1						
		on 1/5/24 at 1:36 p.m., RN 4 old policy would be signed by					
		resident was unable to sign or					
	no family were pres						
	<i>y</i> 2.22 proc						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155753		(X2) MULTIPLE (A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 09/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 966 N WILSON RD SCOTTSBURG, IN 47170				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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	(X5) COMPLETION DATE	
	indicated she had th	on 1/5/24 at 1:40 p.m., LPN 5 are resident if able or the family olicy when transferred to the					
	Regional Director of she had the DHS (I implement an action resident to appoints	or on 1/5/24 at 1:53 p.m., the of Clinical Operations indicated Director of Health Services) in plan on what to send with the ments and the hospital and sident or family sign.					
	DHS indicated she 12/4/23. She had in related to the paper the resident when g hospital. This inclu family sign the bed	n 1/5/24 also at 1:53 p.m., the developed an action plan on serviced the nurses, on 12/5/23, work needed to accompany oing to appointments or the ded having the resident or hold policy. She then did dents who went out to the 23 for compliance.					
	Transfer and Disch included, but was n Notice of Bed-Hold Before the facility thospitalNursing smember should proresident and a fami representative of the policies. c. In cases notice of the bed-hold to the resident or re 24 hours of the transfer.	at policy on Guidelines for arge (Including AMA) of limited to, "Procedures: 5. I Policy and Readmission:b. ransfers a resident to a taff or other designated staff vide written information to the ly member or legal e bed-hold and admission of emergency transfers, the old policy should be provided sident's representative within sferd. Social Services should nation the following business					
	day to assure writte the resident and a fa representative of th	n information was provided to amily member or legal e bed-hold and admission on of bed-Hold Policy and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
11.212111		155753	B. WING			01/09/	
	PROVIDER OR SUPPLIER			966 N W	DDRESS, CITY, STATE, ZIP COD VILSON RD SBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		d be provided via certified mail ation was not provided as part process."					
	The facility's current Bed Hold Policy - Policies						
		venue Billing and Collections					
		ot limited to, "Policy: The ly inform residents in advance					
		ake bed-hold payments as well					
	as the amount of the	e facility's charge to hold a					
	bedPurpose: 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 noncompli	iance began on 12/4/23 and the					
		orrected by 1/4/24 after the					
		d a systemic plan that included					
	_	ns: The facility completed					
		the discharge process and 2/5/23) and all residents					
		ospital after 12/4/23 were					
	audited to ensure 10	00% compliance on					
	transfers/discharges	to the hospital.					
	3.1-12(a)(25)						
	3.1-12(a)(26)						
F 0812	483.60(i)(1)(2)						
SS=F	Food						
Bldg. 00		e/Prepare/Serve-Sanitary					
	The facility must -	afety requirements.					
	,						
	_ ,,,,,	ocure food from sources					
		dered satisfactory by					
	federal, state or lo	cai autnorities. le food items obtained					
	.,	producers, subject to					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155753	B. W	ING		01/09/	2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 966 N WILSON RD SCOTTSBURG, IN 47170				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. 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'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i.c	DATE
	applicable State a regulations. (ii) This provision of facilities from using gardens, subject the applicable safe graphicable safe gractices. (iii) This provision from consuming for facility. §483.60(i)(2) - Store serve food in according safe on observation failed to ensure the sanitary manner for deficient practice has residents currently for the sanitary manner for deficient practice has residents currently for the sanitary manner for deficient practice has residents currently for the sanitary manner for deficient practice has residents currently for the sanitary manner for deficient practice has residents currently for the sanitary manner for deficient practice for the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has been successful to the sanitary manner for deficient practice has	does not prohibit or prevent g produce grown in facility to compliance with owing and food-handling does not preclude residents bods not procured by the ore, prepare, distribute and ordance with professional diservice safety. On and interview, the facility kitchen was maintained in a set 4 of 4 observations. This ad the potential to affect all 65 residing at the facility. All tour of the kitchen on 1/2/24 and 9:40 a.m. while accompanied food Service, the following rived: The steamer had a dinner plate on it along with tan food hwasher had a heavy soil of food crumbs and grease. The a heavy coat of dried black black crumbs on the tray in the Director of Food Service the that the cooks scraped it off	F 08		1 What corrective action will be accomplished for thos residents found to have been affected by the deficient practice? No adverse effects occurred residents due to alleged deficient practice. 2 How other resident having the potential to be affected by the same deficien 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 mat to ensure the deficient practic	to nt de	01/29/2024

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/09/2024		
	PROVIDER OR SUPPLIER		966 N	ADDRESS, CITY, STATE, ZIP COD WILSON RD TSBURG, IN 47170	
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	- The right side of the sheavy coat of yellow particles The entire length of hood near the ceilin grease with gray du - The shelf under the stove had various and spots on it The Walk-in fridg area surrounding the walk in had a 2 foot entire length of the of gray greasy dust. electric cord to the ledor was coated with dust. The fans were were open boxes of shelves The fryer had a magnitudes in the oil The stove burners particles in the oil The stove burners particles on them. 2. During the lunch kitchen on 1/2/24 be p.m., the following - The same issues ic linside the sandwice moderate amount of particles on the bott outside of the unit he particles on it The toaster unit - the top rack and a he under the 2 chains the able to be scraped we had a fixed to be scraped we ha	the stove next to the grill and tove next to the fryer had a w and brown grease and food of the metal strip of the range g had a heavy coat of brown st stuck to it. It is main prep counter in front of its small piece of food particles are 2 condenser fan covers, the end fans and the ceiling of the swide section that ran the unit with a moderate coating. The entire length of silver the hadron to gray running at this time and there warious produce items on the oderate amount of brown food had a build up of brown food had a build up of brown food meal observation in the etween 11:20 a.m. and 12: 30 concerns were observed: Identified at 9:10 a.m. remained. The station, there was a forown and yellow food om shelf and the entire had streaks and brown food there were brown crumbs on eavy build-up of black debris that propelled the racks was		does not recur? As a measure of ongoing compliance, DFS/Designee monitor daily and weekly cleaning both visually and cleaning lists. DFS/Designe will conduct sanitation aud X a week x 4 weeks, then to weekly x 2 months, then weekly x 3 months. 4 How the corrective action(s) will be monitored ensure the deficient practic will not recur? As a quality measure, the Executive Director/Designe will review any findings and corrective actions at least quarterly in the campus Quassurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and continue until 100% complisis maintained.	will by ee it 5 vice to ce d allity e

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		l í	UILDING	00	COMPL 01/09/	ETED	
NAME OF P	ROVIDER OR SUPPLIER				NDDRESS, CITY, STATE, ZIP COD		
HAMPTO	N OAKS HEALTH	CAMPUS			SBURG, IN 47170		
(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
		l fish was observed on the					
	between 10:55 a.m. concerns were obse	observation on 1/4/24 and 11:30 a.m., the following rved:					
	a.m. and 11:10 a.m.	remained.					
		d a heavy build-up of black there were black and yellow					
	The Assistant Dieta time that the grill w	tray in front of the grates. ry Manager indicated at this as last used the previous					
	the steamer was gordried spots.	on puddle on the shelf below ne, there was still multiple					
	with 4 french fries u - The toaster remain	emained under the fryer along under the fryer and stove floor. led with a black substance d a heavy build up of bread					
	crumbs on the botto	m ledge and under the					
	heavy yellow/brown hood below the filte	the range hood remained with a grease and the section of the ers between the stove, grill, an had a heavy coating of					
	- Although a Dietar sweeping the floor	y Aide was observed under the shelving racks, a lid remained on the floor under					
	p.m. with the Direct	observation on 1/8/24 at 1:10 for and Assistant Director of following concerns were					
	- The same issues io	lentified on 1/2/24 at 9:10 a.m.					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155753 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155753		ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/09/	ETED	
	PROVIDER OR SUPPLIEF			966 N V	DDRESS, CITY, STATE, ZIP COD VILSON RD SBURG, IN 47170		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
PREFIX TAG	and 11:10 a.m. and remained. The shelf under the spots on it. The sandwich stat remained the same, there was yellow are outside edge of the one of the wells. The front ledge he yellow/brown greast below the filters be convection oven resulting the yellow/brown greast below the filters be convection oven resulting the yellow/brown greast below the filters be convection oven resulting the yellow/brown greast and the outside of the them. The tops of the flow is the yellow/brown greast and the outside of the bins were soiled with and the outside of the streaks down the error the yellow/black dried the yellow is the yellow in the yellow is the yellow in the yellow is the yellow in the yellow in the yellow is the yellow in the yellow is the yellow in the yellow is the yellow in the yellow in the yellow in the yellow in the yellow is the yellow in	e steamer had multiple dried ion inside bottom cabinet When the cover was lifted, id brown food debris along the wells with wilted lettuce inside ood remains with heavy se, the section of the hood tween the stove, grill and mains with a heavy coating of se. bur, sugar and bread crumb th a white powdery substance he bins had dirt streaks on eam table had dried water attire front. It prep sink had a heavy soil of food particles. The stove, grill and convection uild up of grease and food piece of fish were now gone. ov on 1/8/24 at 1:23 p.m., the of Food Services indicated that in outside company who came let, but did not know how often the the company came in. esponsible for cleaning the		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	DATE
	Director of Food So cooks and staff had some of the things,	or on 1/8/24 at 1:25 p.m., the ervices indicated the afternoon more time to do the cleaning, like the stove burners were left ad of the morning cooks. All					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		A. BUILDING B. WING	00		LETED 0/2024	
	PROVIDER OR SUPPLIER		966 N	ADDRESS, CITY, STATE, ZIP COD WILSON RD FSBURG, IN 47170		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
IAG	the staff should be composed to strain the after using it. During an interview Maintenance Direct walk-in refrigerator same time as the our clean the range hood this month and that the fans when they outside company in facility on 7/9/23. On 1/9/24 at 9:00 a. Services presented a cleaning schedules, the cooks and dietar schedules indicated signed off as being of this time period: a. AM Cook Cleaning - Steamer - wipe dow - Charbroiler - grate hose. - Charbroiler Drip T foil. - Toaster - clean and - Convection ovens, - Back wall behind on - Prep table clean - in the suppose of the suppose of the suppose of the strain of the strain of the strain of the suppose of the sup	cleaning the sides of the stove oven. The cooks were ne food crumbs from the oil on 1/8/24 at 1:30 p.m., the or indicated he cleaned the fans every six months at the tside company came in to d. They were due to come in the would take care of cleaning came in. The receipt from the dicated they were last in the m., the Director of Food a copy of the as-completed dated 12/31/23 to 1/6/24, for y aides. Review of the the following tasks were completed each day during ng Schedule: wn. n and strained. s clean, wiped down including ray emptied and relined with If free of crumbs. including hose.	IAG	DETERMENT		DATE
	equipment. b. AM Aide Cleanir - Dishwasher cleane					

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		IDENTIFICATION NUMBER 155753	I .	JILDING	00	COMPL 01/09/	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 966 N WILSON RD SCOTTSBURG, IN 47170				
(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)	ΓE	(X5) COMPLETION DATE
R 0000 Bldg. 00	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) This visit was for a State Residential Licensure Survey. This visit included a Recertification and		R 0000		On January 9, 2024, Hampton Oaks Health Campus 966 Nor Wilson Road Scottsburg, India	th	
	Facility number: 00-Residential Census:	ry 2, 3, 4, 5, 8, and 9, 2024 4902			47170 Survey Event ID 665Q1 The submission of this Plan of Correction does not indicate an admission by Hampton Oaks Health Campus that the finding and allegations contained here are accurate and true representations of the quality of care and services provided to	n gs sin	
	accordance with 410 Quality review com	O IAC 16.2-5. pleted on January 16, 2024.			residents of Hampton Oaks He Campus. This facility recogniz its obligation to provide legally medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it in substantial compliance with	ealth red and r. is	

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 B. WING			COMPLETED	
		155753	B. W	ING		01/09/	2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 966 N WILSON RD SCOTTSBURG, IN 47170				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	I	ID	DROVIDEDIC 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
R 0273 Bldg. 00	(f) All food prepara (excluding areas in maintained in acco	nal Services - Deficiency ation and serving areas n residents ' units) are ordance with state and d safe food handling			requirements of participation for comprehensive health care facilities (for Title 18/19 programs). Attached you will our Plan of Correction for Ham Oaks Health Campus for our annual survey conducted on September 23, 2014. We initimediate interventions when concerns were identified on the date. We respectfully request paper review for this plan of correction. If you need any information or paperwork, plead on not hesitate to contact us a (812)752-2694. Sincerely, Bra Royalty, Executive Director.	find npton ated is	
	Based on observation failed to ensure the sanitary manner for deficient practice has	on and interview, the facility kitchen was maintained in a 4 of 4 observations. This ad the potential to affect all 22 s currently residing at the	R 02	273	1 What corrective action will be accomplished for the residents found to have been affected by the deficient practice? No adverse effects occurred residents due to alleged deficient practice. 2 How other resident	1	01/29/2024
	between 9:10 a.m. a	I tour of the kitchen on 1/2/24 and 9:40 a.m. while accompanied ood Service, the following rved:			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	d	

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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. BUILDING 00		00	COMPLETED		
		155753	B. WING			01/09/2024		
				_				
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
					WILSON RD			
HAMPTO	ON OAKS HEALTH	CAMPUS		SCOTTSBURG, IN 47170				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	' ⁻	DATE	
	- The shelf below the	ne steamer had a dinner plate			potential to be affected by the			
		on it along with tan food			alleged deficient practice.			
	particles.				Director of food			
	^	hwasher had a heavy soil of			services/Designee will			
	_	Good crumbs and grease.			in-service all dietary staff on			
		a heavy coat of dried black			cleaning schedule and			
	_	black crumbs on the tray in			sanitation expectations.			
		ne Director of Food Service			3 What measures will be			
	_	ne that the cooks scraped it off			put into place, and what			
	after each time they	*			systemic changes will be ma	de		
	1	e convection oven next to the			to ensure the deficient practi			
	grill had a heavy coat of yellow/brown grease and				does not recur?			
	food particles.				As a measure of ongoing			
	- The right side of the stove next to the grill and				compliance, DFS/Designee w	/ill		
	the left side of the stove next to the fryer had a				monitor daily and weekly			
	heavy coat of yellow and brown grease and food				cleaning both visually and by	,		
	particles.				cleaning lists. DFS/Designee			
	- The entire length of the metal strip of the range				will conduct sanitation audit			
	hood near the ceiling had a heavy coat of brown				a week x 4 weeks, then twice	,		
	grease with gray dust stuck to it.				weekly x 2 months, then			
	- The shelf under the main prep counter in front of				weekly x 3 months.			
	the stove had various small piece of food particles							
	and spots on it.				4 How the corrective			
	- The Walk-in fridge 2 condenser fan covers, the				action(s) will be monitored to	, l		
	area surrounding the fans and the ceiling of the				ensure the deficient practice			
	walk in had a 2 foot wide section that ran the				will not recur?			
	entire length of the unit with a moderate coating				As a quality measure, the			
	of gray greasy dust	. The entire length of silver			Executive Director/Designee			
	electric cord to the	light fixture above the entrance			will review any findings and			
	door was coated with a moderate amount of gray				corrective actions at least			
	dust. The fans were running at this time and there				quarterly in the campus Qua	lity		
	were open boxes of various produce items on the				Assurance Performance	_		
	shelves.			Improvement meetings. The				
	- The fryer had a moderate amount of brown food			plan will be reviewed and				
	particles in the oil.				updated as warranted and w	ill		
	- The stove burners	had a build up of brown food			continue until 100% complia	nce		
	particles on them.				is maintained.			
	2. During the lunch	meal observation in the						
kitchen on 1/2/24 between 11:20 a.m. and 12: 30								

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		r í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/09/	ETED				
NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 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			
	- The same issues in a line in the top rack and a hunder the 2 chains the top rack and a hunder the 2 chains the top rack and a hunder the 2 chains the top rack and a hunder the 2 chains the top rack and a hunder the fryer are frozen fish and friesteam table for lunder the fryer are frozen fish and friesteam table for lunder the steam table for lunder the grill grates had be steamer that the grill we were the steamer was good the steamer was good dried spots. - The piece of fish in with 4 french fries the toaster remain under the chains an crumbs on the botto toaster. - The front ledge of heavy yellow/brow	and steamer was a piece of d fish was observed on the eth. a observation on 1/4/24 and 11:30 a.m., the following erved: as identified on 1/2/24 at 9:10								

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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	A. BUILDING <u>00</u>			COMPLETED	
		155753	B. W	B. WING		01/09/	/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF	PROVIDER OR SUPPLIEF	₹			VILSON RD			
HAMPTO	ON OAKS HEALTH	CAMPUS			SBURG, IN 47170			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR		ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		n had a heavy coating of						
	yellow/brown greas							
		y Aide was observed						
		under the shelving racks, a						
		lid remained on the floor under						
	the cereal and micro	owave counter.						
	4. During a kitchen	observation on 1/8/24 at 1:10						
		tor 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							
		wells with wilted lettuce inside						
	one of the wells.	West with the second second						
	- 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							
	_	th a white powdery substance						
	and the outside of the bins had dirt streaks on							
	them.							
	- The front of the st	team 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753			JILDING	nstruction 00	(X3) DATE COMPL 01/09/	ETED			
NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 966 N WILSON RD SCOTTSBURG, IN 47170						
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DECLINATION OF LOCALITY AND			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION		
TAG	During an interview Assistant Director of Maintenance had an in to clean the hood or when the last tim Maintenance was refans in the walk-in During an interview Director of Food So cooks and staff had some of the things, to them to do insteat the staff should be and the convection supposed to strain the after using it. During an interview Maintenance Director walk-in refrigerators same time as the own clean the range hood this month and that the fans when they outside company in facility on 7/9/23. On 1/9/24 at 9:00 a Services presented cleaning schedules, the cooks and dietat schedules indicated	or on 1/8/24 at 1:25 p.m., the ervices indicated the afternoon more time to do the cleaning, like the stove burners were left and of the morning cooks. All cleaning the sides of the stove oven. The cooks were the food crumbs from the oil of the food crumbs from the oil of the store indicated the cleaned the frans every six months at the staide company came in to do. They were due to come in the would take care of cleaning came in. The receipt from the adicated they were last in the company of the as-completed dated 12/31/23 to 1/6/24, for rry aides. Review of the the following tasks were completed each day during schedule:		TAG	DEFICIENCY		DATE		
	- Charbroiler - grates clean, wiped down including								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155753	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2024		
NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 966 N WILSON RD SCOTTSBURG, IN 47170					
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