STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155753	A. BUILDING -- B. WING	01/25/2024

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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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/25/24 Facility Number: 004902 Provider Number: 155753 AIM Number: 200813130 At this Emergency Preparedness survey, Hampton Oaks Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 71 certified beds. At the time of the survey, the census was 62. Quality Review completed on 01/30/24	E 0000	January 25, 2024 Hampton Oaks Health Campus 966 North Wilson Road Scottsburg, Indiana 47170 Survey Event ID 66Q21. 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 Life Safety visit survey conducted on January 25, 2024. We initiated immediate intervention when concerns were identified on this date. We respectfully request desk 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, Administrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandy Royalty	Executive Director	02/14/2024

Any defiencystatement 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/25/24 Facility Number: 004902 Provider Number: 155753 AIM Number: 200813130 At this Life Safety Code survey, Hampton Oaks Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in all resident sleeping rooms. The facility has a capacity of 71 and had a census of 62 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 01/30/24	K 0000	January 25, 2024 Hampton Oaks Health Campus 966 North Wilson Road Scottsburg, Indiana 47170 Survey Event ID 66Q21. 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 Life Safety visit survey conducted on January 25, 2024. We initiated immediate intervention when concerns were identified on this date. We respectfully request desk 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, Administrator	

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K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:35 p.m. to 2:10 p.m. on 01/25/24, the battery operated lighting system affixed to the wall above the exit door set to the outside of the facility in the main electrical room which houses the emergency generator transfer switch failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the DPO agreed the aforementioned battery powered emergency lighting system failed to illuminate when its respective test button was pushed multiple times. These findings were reviewed with the Executive Director, the DPO and the Facilities Management	K 0291	**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?** **The battery was replaced to the emergency lighting that is affixed to the wall above the exit door set to the outside of the facility in the main electrical room which houses the emergency generator transfer switch failed to illuminate when its respective test button was pushed multiple times.** 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, DPO or designee**	02/15/2024

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	Support during the exit conference. 3.1-19(b)		**will test battery to emergency lighting in main electrical room monthly and long into Tels. DPO was educated on regulation and requirement to log functionality of emergency battery monthly and log into Tels.** **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.**	
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for			

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	integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 2010 Edition. Section 10.5.5.2.1 states, the location of the dedicated branch circuit disconnecting means shall be permanently identified at the control unit. Section 10.5.5.2.2 states, for fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." Section 10.5.5.2.3 states for fire alarm systems the circuit disconnecting means shall have a red marking. Section 10.5.5.2.4 states the circuit disconnecting means shall be accessible only to authorized personnel. Section 10.5.5.3 states the dedicated branch circuit(s) and connections shall be protected against physical damage. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:35 p.m. to 2:10 p.m. on 01/25/24, access to the fire alarm circuit breaker in the wall mounted electrical panel identified as "X2" in the supply room near the east nurse's station was not restricted. Based on interview at the time of the observations, the DPO agreed the dedicated branch circuit disconnecting means for the facility's fire alarm system was not locked and locked the door to the room at the time of the observations. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference.	K 0341	**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?** **DPO placed a lock on Breaker # 18 in the nurse supply room.** **DPO placed a key pad to the nurse supply room door allowing for the door to be locked at all times and a code is used to enter.** 3 What measures will be put into place, and what systemic changes will be made to ensure the deficient practice does not recur? **Correction has allowed for the electrical panel to be secure at all times. DPO educated on regulation.** **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**	02/15/2024

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	3.1-19(b)		**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.**	
K 0344 SS=F Bldg. 01	NFPA 101 Fire Alarm - Control Functions Fire Alarm - Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72 Based on record review, observation and interview; the facility failed to ensure all fire alarm system emergency control functions were maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Table 14.4.5(18) states interface equipment and emergency control functions shall be tested annually. Table 14.4.2.2(23) defines smoke damper operation as an emergency control function. Testing frequency for emergency control function shall be the same as the initiating device that activates the emergency control function. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0344	**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?** **Safe Care did a damper inspection on smoke damper identified in HVAC ductwork in the attic above the corridor door set to the main dining room by therapy room. This inspection was completed on 2/8/2024 and has been added to the annual inspection.** 3 What measures will be put	02/15/2024

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	Based on review of facility blueprint documentation during record review from 10:20 a.m. to 12:35 p.m. on 01/25/24, a 2-hour fire resistance rated fire wall is constructed at the entrance to the main dining room by the therapy room. Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:35 p.m. to 2:10 p.m. on 01/25/24, two smoke dampers were noted in HVAC ductwork in the attic above the corridor door set to the main dining room by the therapy room. Based on review of the fire alarm system inspection contractor's "Fire Alarm System Inspection" documentation dated 03/06/23 with the DPO and the Facilities Management Support at 2:10 p.m. on 01/25/24, smoke damper inspection and testing documentation for the most recent twelve month period was not available for review. Based on interview at the time of the observations, the DPO agreed it could not be ensured all smoke dampers in the facility were inspected or tested within the most recent twelve month period. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		into place, and what systemic changes will be made to ensure the deficient practice does not recur? **DPO will ensure that annual inspection occurs annually and log results in Tels system for compliance tracking every year when completed. DPO educated on regulation.** **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.**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes.			

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	Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 20 residents in the vicinity of the corridor smoke barrier door set by the therapy room. Findings include: Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:35 p.m. to 2:10 p.m. on 01/25/24, an astragal was affixed to the south door in the corridor smoke barrier door set by the therapy room. A gap of greater than 1/8 inch was noted between the astragal and the north door in the door set just above the floor when the door set was in the fully closed position. Based on interview at the time of the observations, the DPO agreed the gap in between the meeting edges of the corridor door set would not resist the passage of smoke when the door set was in the fully closed position. These findings were reviewed with the Executive	K 0374	**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?** **Metal has been replaced on the South door in the corridor smoke barrier door set by the therapy room. This will correct the 1/8 inch gap identified between the astragal and the north door set just above the floor when the door is in fully closed position.** 3 What measures will be put into place, and what systemic changes will be made to ensure the deficient practice does not recur? **DPO will round during monthly fire drills to ensure proper closure and long in Tels. DPO**	02/15/2024

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	Director, the Director of Plant Operations (DPO) and the Facilities Management Support during the exit conference. 3.1-19(b)		**educated on regulation and requirement of monthly rounding and logging findings during fire drill.** **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.**	