PRINTED: 02/15/2024

CENTERS FOR MEDICARE & MEDICAID SERVICES						MB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753			(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/25/2024	
NAME OF	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD WILSON RD		
HAMPTON OAKS HEALTH CAMPUS				TSBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	*	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF			DEFICIENCY)		DATE
E 0000						
Bldg	conducted by the Ir accordance with 42  Survey Date: 01/25  Facility Number: 0 Provider Number: AIM Number: 200  At this Emergency Hampton Oaks Hea compliance with En Requirements for Nearticipating Provided 483.73  The facility has 71 the survey, the cens	5/24  104902 155753 813130  Preparedness survey, 10th Campus was found in 10th mergency Preparedness 10th Medicaid 10th derivative and Medicaid 10th derivative and Suppliers, 42 CFR  10th Certified beds. At the time of	E 0000	January 25, 2024 Hampton Health Campus 966 North Williams Scottsburg, Indiana 47 Survey Event ID 66Q21. The submission of this Plan of Correction does not indicate admission by Hampton Oaks Health Campus that the find and allegations contained he are accurate and true representations of the quality care and services provided to residents of Hampton Oaks Campus. This facility recognits obligation to provide legal medically necessary care and services to its residents in an economic and efficient manner The facility hereby maintains in substantial compliance will requirements of participation comprehensive health care facilities (for Title 18/19 programs). Attached you will our Plan of Correction for Hampton Oaks Health Campus for our Safety visit survey conducted January 25, 2024. We initial immediate intervention where concerns were identified on date. We respectfully requested the survey of this plan of correction. If you need any	Vilson 7170 e an s ings erein y of to the Health nized Illy and n ner. s it is th the n for ill find ampton r Life d on ted n this	

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

(X6) DATE

information or paperwork, please do not hesitate to contact us at (812) 752-2694. Sincerely, Brandy Royalty, Administrator

TITLE

**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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D		(X3) DATE	3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155753	B. WING			01/25/2024	
NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD  966 N WILSON RD  SCOTTSBURG, IN 47170				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		BROWINEDIC DI ANI OF CORRECTION		(X5)
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TAG							DATE
K 0000							
K 0000 Bldg. 01	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 01/25  Facility Number: 01 Provider Number: 12 AIM Number: 2008  At this Life Safety C Health Campus was Requirements for Pa Medicare/Medicaid, Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupa  This one story facilit Type V (111) constr sprinklered. The fact with hard wired smost spaces open to the c sleeping rooms. Th and had a census of	204902 20155753 2013130 200de survey, Hampton Oaks 20155753 2013130 200de survey, Hampton Oaks 20155753 2013130 20155753	K 00	000	January 25, 2024 Hampton Of Health Campus 966 North Will Road Scottsburg, Indiana 471 Survey Event ID 66Q21. The submission of this Plan of Correction does not indicate a admission by Hampton Oaks Health Campus that the findin and allegations contained here are accurate and true representations of the quality care and services provided to residents of Hampton Oaks Howard Campus. This facility recognizits obligation to provide legally medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains in substantial compliance with requirements of participation from prehensive health care facilities (for Title 18/19 programs). Attached you will our Plan of Correction for Ham Oaks Health Campus for our Legalety visit survey conducted January 25, 2024. We initiate immediate intervention when concerns were identified on the date. We respectfully request desk review for this plan of correction. If you need any information or paperwork, plead on not hesitate to contact us at (812) 752-2694. Sincerely, Brandy Royalty Administrator.	son 70  In gs ein of the ealth zed or and the tis the for find on the condition on the condition of the cond	

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Event ID:

665Q21

Facility ID: 004902

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02/15/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155753 B. WING 01/25/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 966 N WILSON RD HAMPTON OAKS HEALTH CAMPUS SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE K 0291 **NFPA 101** SS=F **Emergency Lighting** Bldg. 01 **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 K 0291 02/15/2024 What corrective action will failed to ensure 1 of 1 battery powered emergency be accomplished for those lighting systems was maintained in accordance residents found to have been with LSC Section 7.9. LSC 7.9.2.6 states battery affected by the deficient operated emergency lights shall use only reliable practice? types of rechargeable batteries provided with No adverse effects occurred to suitable facilities for maintaining them in properly residents due to alleged charged condition. Batteries used in such lights deficient practices. or units shall be approved for their intended use How other residents having and shall comply with NFPA 70, National Electric the potential to be affected by Code. This deficient practice could affect all the same deficient practice will residents, staff and visitors. be identified and what corrective action(s)will be Findings include: taken? The battery was replaced to Based on observations with the Director of Plant the emergency lighting that is Operations (DPO) and the Facilities Management affixed to the wall above the Support during a tour of the facility from 12:35 exit door set to the outside of p.m. to 2:10 p.m. on 01/25/24, the battery operated the facility in the main lighting system affixed to the wall above the exit electrical room which houses door set to the outside of the facility in the main the emergency generator electrical room which houses the emergency transfer switch failed to generator transfer switch failed to illuminate when illuminate when its respective its respective test button was pushed multiple test button was pushed times. Based on interview at the time of the multiple times. observations, the DPO agreed the aforementioned What measures will be put battery powered emergency lighting system failed into place, and what systemic to illuminate when its respective test button was changes will be made to ensure

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pushed multiple times.

These findings were reviewed with the Executive

Director, the DPO and the Facilities Management

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recur?

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the deficient practice does not

compliance, DPO or designee

As a measure of ongoing

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/25/2024				
	PROVIDER OR SUPPLIER		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		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION			
TAG	Support during the 3.1-19(b)	exit conference.	TAG	will test battery to emergence lighting in main electrical romonthly and long into Tels. DPO was educated on regulation and requirement log functionality of emergent 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 came Quality Assurance Performate Improvement meetings. The plan will be reviewed and updated as warranted and we continue until 100% compliations maintained.	om  to cy  on pus ince			
K 0341 SS=F Bldg. 01	and components a accordance with N Code, and NFPA Code to provide e part of the building occupied, detection alarm control unit. detection is also in appliance circuit p supervising station Fire alarm system	n - Installation m is installed with systems approved for the purpose in IFPA 70, National Electric 72, National Fire Alarm ffective warning of fire in any g. In areas not continuously on is installed at each fire In new occupancy, estalled at notification ower extenders, and in transmitting equipment.						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		a. building <u>01</u>		COMPLETED	
		155753	B. WING			01/25/2024	
NAME OF I	DROLUDED OD GUIDDI IEE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				966 N V	WILSON RD		
HAMPTON OAKS HEALTH CAMPUS					SBURG, 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 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE C	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCE		DATE
	integrity.	06 06 1 8					
	18.3.4.1, 19.3.4.1	on and interview, the facility	L O	2.41	1 What corrective action v	,;iii	02/15/2024
		of 1 fire alarm systems in	K 0	341	1 What corrective action v be accomplished for those	vIII   (	)2/15/2024
		FPA 72, National Fire Alarm			residents found to have been	_	
		. Section 10.5.5.2.1 states, the			affected by the deficient	''	
		cated branch circuit			practice?		
		as shall be permanently			No adverse effects occurred	to	
	_	ntrol unit. Section 10.5.5.2.2			residents due to alleged		
		n systems the circuit			deficient practices.		
	disconnecting means shall be identified as "FIRE				2 How other residents have	ring	
	_	"." Section 10.5.5.2.3 states for			the potential to be affected by	- 1	
	fire alarm systems t	the circuit disconnecting means			the same deficient practice v	-	
	shall have a red ma	rking. Section 10.5.5.2.4 states			be identified and what		
	the circuit disconnecting means shall be		correc		corrective action(s)will be		
	accessible only to a	uthorized personnel. Section			taken?		
	10.5.5.3 states the d	ledicated branch circuit(s) and			DPO placed a lock on Break	er	
	connections shall be	e protected against physical			# 18 in the nurse supply roo	m.	
	-	eient practice could affect all			DPO placed a key pad to the		
	residents, staff and	visitors.		nurse supply room door			
					allowing for the door to be		
	Findings include:				locked at all times and a cod	le	
					is used to enter.		
		ons with the Director of Plant			3 What measures will be pu		
		and the Facilities Management			into place, and what systemic		
		ur of the facility from 12:35			changes will be made to ensu		
		n 01/25/24, access to the fire			the deficient practice does no	[	
		er in the wall mounted electrical			recur?		
	_	'X2" in the supply room near			Correction has allowed for the		
		ion was not restricted. Based time of the observations, the			electrical panel to be secure at		
		dicated branch circuit			all times. DPO educated on		
	_	ns for the facility's fire alarm		regulation.  4 How the corrective			
	_	ked and locked the door to the		4 How the corrective action(s) will be monitored to		,	
	room at the time of				ensure the deficient practice		
	130m at the time of	me coservations.			will not recur?	·	
	These findings were	e reviewed with the Executive			As a quality measure, the		
	_	and the Facilities Management			Executive Director (ED) or		
	Support during the	C			designee will review any	1	
	11				findings and corrective action	on	

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			ETED
155753		B. WING 01/25/2024					
NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 966 N WILSON RD SCOTTSBURG, IN 47170				
(X4) ID	SUMMARY	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
	3.1-19(b)				at least quarterly in the camp Quality Assurance Performal Improvement meetings. The plan will be reviewed and updated as warranted and wi continue until 100% complia- is maintained.	ill	
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		K 0	344	1 What corrective action was 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 was identified and what corrective action(s) will be taken? Safe Care did a damper inspection on smoke damper inspection was completed or 2/8/2024 and has been added the annual inspection.	to ring vill	02/15/2024
		cient practice could affect all			inspection was completed or	n d to	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 01/25/2024					
NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS			966 N	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	(X5) COMPLETION DATE					
	a.m. to 12:35 p.m. or resistance rated fire entrance to the main room. Based on ob Plant Operations (D. Management Supportion 12:35 p.m. to smoke dampers were the attic above the ordining room by the review of the fire all contractor's "Fire A documentation date the Facilities Manago 1/25/24, smoke dare documentation for the period was not available in the facility were most recent twelve.	ng record review from 10:20 on 01/25/24, a 2-hour fire wall is constructed at the a dining room by the therapy servations with the Director of 1PO) and the Facilities of during a tour of the facility 2:10 p.m. on 01/25/24, two re noted in HVAC ductwork in corridor door set to the main therapy room. Based on arm system inspection larm System Inspection do3/06/23 with the DPO and gement Support at 2:10 p.m. on mper inspection and testing the most recent twelve month lable for review. Based on the of the observations, the DPO one ensured all smoke dampers inspected or tested within the month period.		into place, and what systemichanges will be made to ensithe deficient practice does not recur?  DPO will ensure that annual inspection occurs annually log results in Tels system for compliance tracking every when completed. DPO educated on regulation.  4 How the corrective action(s) will be monitored ensure the deficient practic will not recur?  As a quality measure, the Executive Director (ED) or designee will review any findings and corrective actional teleast quarterly in the can Quality Assurance Perform Improvement meetings. The plan will be reviewed and updated as warranted and continue until 100% complisis maintained.	aure ot  II and or year  to ce  ion npus ance ne				
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood	Iding Spaces - Smoke  Iding Spaces - Smoke  arriers are 1-3/4-inch thick d-core doors or of esists fire for 20 minutes.							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/25/2024 155753 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 966 N WILSON RD HAMPTON OAKS HEALTH CAMPUS SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0374 What corrective action will 02/15/2024 failed to ensure 1 of 5 sets of smoke barrier doors be accomplished for those would restrict the movement of smoke for at least residents found to have been 20 minutes. LSC, Section 19.3.7.8 requires that affected by the deficient doors in smoke barriers shall comply with LSC, practice? Section 8.5.4. LSC, Section 8.5.4.1 requires doors No adverse effects occurred to in smoke barriers to close the opening leaving residents due to alleged only the minimum clearance necessary for proper deficient practices. operation which is defined as 1/8 inch to restrict 2 How other residents having the movement of smoke. This deficient practice the potential to be affected by affects 20 residents in the vicinity of the corridor the same deficient practice will smoke barrier door set by the therapy room. be identified and what corrective action(s)will be Findings include: taken? Metal has been replaced on Based on observations with the Director of Plant the South door in the corridor Operations (DPO) and the Facilities Management smoke barrier door set by the Support during a tour of the facility from 12:35 therapy room. This will correct p.m. to 2:10 p.m. on 01/25/24, an astragal was the 1/8 inch gap identified affixed to the south door in the corridor smoke between the astragal and the barrier door set by the therapy room. A gap of north door set just above the greater than 1/8 inch was noted between the floor when the door is in fully astragal and the north door in the door set just closed position. above the floor when the door set was in the fully What measures will be put closed position. Based on interview at the time of into place, and what systemic the observations, the DPO agreed the gap in changes will be made to ensure between the meeting edges of the corridor door the deficient practice does not set would not resist the passage of smoke when recur? the door set was in the fully closed position. **DPO** will round during monthly

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These findings were reviewed with the Executive

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fire drills to ensure proper

closure and long in Tels. DPO

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2024 FORM APPROVED OMB NO. 0938-039

CENTERS I OI	T OF PERIORS	THE SERVICES	770.3.6		NAME OF THE OWNER OWNER OF THE OWNER	0111	arina (1777)		
l		l í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	ILDING	01	COMPL	LETED			
155753		B. WI	NG		01/25/	/2024			
				CTREET	ADDRESS, CITY, STATE, ZIP COD				
NAME OF I	PROVIDER OR SUPPLIE	R							
LIANADTO	NI OAKO UEALTU	CAMPLIC		966 N WILSON RD					
HAMPIC	N OAKS HEALTH	CAMPUS		50011	SBURG, IN 47170				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	Director, the Direc	tor of Plant Operations (DPO)			educated on regulation and				
	and the Facilities N	Management Support during the			requirement of monthly				
	exit conference.				rounding and logging finding	js			
					during fire drill.	-			
	3.1-19(b)				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 actio	n			
					at least quarterly in the camp				
					Quality Assurance Performan				
					Improvement meetings. The				
					plan will be reviewed and				
				updated as warranted and wi	ill				
				continue until 100% compliar					
					is maintained.	iic <del>c</del>			
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