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

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155753		JILDING	ONSTRUCTION	(X3) DATE COMPL 01/10/	ETED
	PROVIDER OR SUPPLIER		<u> </u>	966 N V	ADDRESS, CITY, STATE, ZIP COD WILSON RD SBURG, IN 47170	<u> </u>	
(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
E 0000	conducted by the In- accordance with 42 Survey Date: 01/10 Facility Number: 00 Provider Number: 1 AIM Number: 2008 At this Emergency I Hampton Oaks Heal compliance with En Requirements for M Participating Provid 483.73	04902 155753 313130 Preparedness survey, Ith Campus was found in nergency Preparedness ledicare and Medicaid ers and Suppliers, 42 CFR	E 00	000	January 26, 2023 Hampton On Health Campus 966 North Will Road Scottsburg, Indiana 471 Survey Event ID Q96421. The submission of this Plan of Correction does not indicate a 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 residents of Hampton Oaks House Campus. This facility recognizits obligation to provide legally medically necessary care and services to its residents in an economic and efficient manne. The facility hereby maintains in substantial compliance with requirements of participation from comprehensive health care facilities (for Title 18/19 programs). Attached you will our Plan of Correction for Ham Oaks Health Campus for our Legaley visit survey conducted January 20, 2023. 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 a (812) 752-2694. Sincerely	son 70 70 70 70 70 71 71 72 72 73 75 76 77 77 77 77 77 77 77 77 77 77 77 77	
					(812) 752-2694. Sincerely, Brandy Royalty, Administrator		
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURI	3	TITLE		(X6) DATE
Brandy Ro	yalty			ED			02/08/2023

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 AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY ETED
	155753	B. WI	B. WING 01			/2023
NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH (966 N \	ADDRESS, CITY, STATE, ZIP COD WILSON RD FSBURG, 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 TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)		DATE
K 0000						
A Life Safety Code Licensure Survey w Department of Heal 483.90(a). Survey Date: 01/10 Facility Number: 00 Provider Number: 1 AIM Number: 2008 At this Life Safety Code Health Campus was Requirements for Pa Medicare/Medicaid, Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa This one-story facilit Type V (111) constructions sprinklered. The fact with hard wired sme spaces open to the c sleeping rooms. Th and had a census of All areas where the	04902 155753 813130 Code survey, Hampton Oaks found not in compliance with articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. ity was determined to be of ruction and was fully cility has a fire alarm system oke detectors in the corridors, corridors, and all resident the facility has a capacity of 71 160 at the time of this survey. residents have customary the sprinklered.	K 00	000	January 26, 2023 Hampton O Health Campus 966 North Wil Road Scottsburg, Indiana 471 Survey Event ID Q96421. 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 H Campus. This facility recogni: its obligation to provide legally medically necessary care and services to its residents in an economic and efficient manne. The facility hereby maintains i in substantial compliance with requirements of participation f comprehensive health care facilities (for Title 18/19 programs). Attached you will our Plan of Correction for Ham Oaks Health Campus for our I Safety visit survey conducted January 20, 2023. We initiate immediate intervention when concerns were identified on th date. We respectfully request desk review for this plan of correction. If you need any information or paperwork, plea do not hesitate to contact us at (812) 752-2694. Sincerely, Brandy Royalty, Administrator	son 70 e an gs ein of the ealth zed / and t is the for find npton Life on d ais	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		(X2) MULTIPLE CONSTRUCTION (X3) DATE: A. BUILDING 01 COMPL B. WING 01/10/			ETED		
	PROVIDER OR SUPPLIER			966 N W	ADDRESS, CITY, STATE, ZIP COD VILSON RD SBURG, IN 47170		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0131 SS=C Bldg. 01	Care Facilities Sections of health other occupancies o They are not in more inpatients fo treatment, or custo o They are separ care occupancies construction ha fire resistance ratin accordance wit o The entire build by an approved, s automatic sprin with Section 9.7. Hospital outpatien required to be class Health Care Occu number of patients 19.1.3.3, 42 CFR 1. Based on observate facility failed to ensemant of the fire doors in a 2-hour separation was been approved to the fire facility failed to ensemant on the fire facility failed and were section of the facility failed to ensemant of the facility failed and were section of the facility failed to ensemant	care facilities classified as meet all of the following: tended to serve four or purposes of housing, omary access. Fated from areas of health by eving a minimum two houring in h Chapter 8. ding is protected throughout supervised elkler system in accordance t surgical departments are sified as an Ambulatory pancy regardless of the	K 013	31	Compliance Date: 5/5/2023 Part 1 Immediate intervention Part A – The Director Plant Operations contacted Lensing Architectural Sales to have the two cross corridor fire doors recertified and retagged Waiver has been requested du potential delay of door delivery See the re-vision of Waiver red on K131 and why waiver requested. Part B & C – The	e l. ue to /.	05/05/2023

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 B. WING 01/10/2023 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE labeled fire door assemblies and fire window **Director of Plant Operations** assemblies and their accompanying hardware, contacted Fitzpatrick construction including all frames, closing devices, anchorage, to replace the doors between the and sills in accordance with the requirements of restorative dining and main dining NFPA 80, Standard for Fire Doors and Other and between the kitchen and main Opening Protectives. 8.3.3.2.2 states all products dining rooms with new 90 minute required shall bear an approved label. This rated fire doors that self-close, deficient practice could affect all residents while in latch properly and have gaps that the dining room and/or adjacent egress corridor. comply with code. Please see added note on Estimate explaining Findings include: why St. Andrews Health Campus was mentioned. Based on observations on 01/10/23 between 11:45 The Director of Plant Operations a.m. and 2:30 p.m. during a tour of the facility with was educated by the Executive the Director of Plant Operations, Executive Director on K 131 NFPA 101 -Director, and Facilities Management Support, the Multiple Occupancies – Sections following was noted: of Health Care Facilities a. Both doors in the set of cross corridor fire LSC 8.3.3.1 states doors that separates the Assisted Living section openings required to have a fire from the skilled health care section of the facility protection rating of 1 ½ in a 2-hour had paint on the fire rating tags. The Director of fire wall or partition shall be Plant Operations attempted to remove the paint at protected by approved, listed, the time of observation but was unable to do so. labeled fire door assemblies and Due to the paint on the fire rating tags, it could fire window assemblies and their not be assured the doors were at least 1 1/2-hour accompanying hardware, including fire rated doors. all frames, closing devices, b. The single fire door between the Restorative anchorage, and sills in Dining Room and the skilled care main dining accordance with the requirements room, part of the 2-hour fire separation between of NFPA 80, Standard for Fire the Assisted living section and the skilled health Doors and Other Opening care section, did not close completely and latch Protectives, 8.3.3.2.2 states all when tested several times. Furthermore, there was products required shall bear an a one-half inch gap at the top of the door when approved label. closed fully. The Director of Plant Operations did The Director of Plant Operations adjust the door during observation so it would will inspect the deficient doors for latch into the door frame. closing, latching, proper labeling c. The single door between the Kitchen and the and gap compliance 1 X a week skilled care main dining room, part of the 2-hour for 1 month and 1 X a month for 3

fire separation between the Assisted living

section and the skilled health care section, had a

months.

Results of these inspections will

02/10/2023 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 B. WING 01/10/2023 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 one-half inch gap along the bottom half of the be presented by Executive latching side of the door when closed fully. Director to the QA committee for These items were acknowledged by the Director further recommendations and of Plant Operations, Facilities Management continue until the Quality Support, and the Executive Director at the time of Assurance Team determines each observation. substantial compliance has been achieved. These findings were reviewed with the Director of The deficient practice could affect Plant Operations, Facilities Management Support, all residents while in the dining and the Executive Director during the exit room and/or adjacent egress conference. corridors. Exhibit A- 90 minute door audit 3.1-19(b)Exhibit C- Other documentation photos 2. Based on observation and interview, the Part 2 facility failed to ensure the penetration in 1 of 1 Compliance date - 1/30/2023 fire barrier wall was maintained to ensure the fire Immediate intervention resistance of the barrier. LSC 19.1.1.3 requires all The Director of Plant Operations health care facilities to be maintained and removed the unapproved operated to minimize the possibility of a fire expandable spray foam from the emergency requiring the evacuation of the penetration in the 2-hour fire wall occupants. LSC 8.3.5.1 requires penetrations for and filled the penetration with an cables, cable trays, conduits, pipes, tubes, approved fire stop material. combustion vents and exhaust vents, wires, and The Director of Plant Operations similar items to accommodate electrical, was educated by the Executive mechanical, plumbing, and communications Director on K 131 NFPA 101 systems that pass through a wall, floor, or Multiple Occupancies – Sections floor/ceiling assembly constructed as a fire barrier of Health Care Facilities shall be protected by a firestop system or device. LSC 8.3.5.1 requires The firestop system or device shall be tested in penetrations for cables, cable accordance with ASTM E 814, Standard Test trays, conduits, pipes, tubes, Method for Fire Tests of Through Penetration Fire combustion vents and exhaust Stops, or ANSI/UL 1479, Standard for Fire Tests vents, wires, and similar items to of Through-Penetration Fire Stops. This deficient accommodate electrical, practice could affect all residents while in the main mechanical, plumbing, and dining room. communications systems that

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Findings include:

Based on an observations on 01/10/23 between

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pass through a wall, floor, or

by a firestop system or device.

floor/ceiling assembly constructed as a fire barrier shall be protected

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IFYING INFORMATION	966 N V	ADDRESS, CITY, STATE, ZIP COD VILSON RD SBURG, IN 47170	
E PRECEDED BY FULL IFYING INFORMATION		DE OVUDEDIG DE AN OF CORDECTION	
og a tour of the facility	TAG	(EACH CORRECTION (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
rations, Facilities Executive Director, section of the setween the kitchen ch was not provided al. The gap was andable spray foam. Director of Plant agement Support at gain during the exit e expandable spray the the Director of anagement Support,		The fire stop system or device shall be tested in accordance ASTM E 814, Standard Test Method for Fire Test of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Firests or Through-Penetration Stops. The Director of Plant Operation will inspect the deficient penetration for compliant fires 1 X a week for 1 month and 1 month for 3 months. Results of these inspections who be presented by Executive Director to the QA committee further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved. The deficient practice could af all residents while in the main dining room. Exhibit A- Fire stop audit Exhibit D – Photos and other documentation	with gh ire Fire ons stop X a vill for
nd accesses are 7, and the means aintained free of case of I by 18/19.2.2	K 0211	Compliance Date- 1/11/2023	01/11/2023
	artering information arg a tour of the facility arations, Facilities Executive Director, section of the between the kitchen ch was not provided al. The gap was andable spray foam. be Director of Plant agement Support at gain during the exit be expandable spray The the Director of anagement Support, aring the exit and accesses are and the means aintained free of a case of a by 18/19.2.2 Triew, the facility	Internation and a tour of the facility rations, Facilities Executive Director, section of the between the kitchen ch was not provided al. The gap was andable spray foam. The policy of Plant agament Support at gain during the exit the expandable spray the the Director of anagement Support, ring the exit the exit that accesses are 7, and the means anintained free of a case of the by 18/19.2.2	PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG The fire stop system or device shall be tested in accordance ASTM E 814, Standard Test Method for Fire Test of Throughenetration Fire Stops, or ANSI/UL 1479, Standard for Fire Stops, or ANSI/UL 1479, Standard for Fire Stops. The Director of Plant agement Support at gain during the exit e expandable spray The fire stop system or device shall be tested in accordance ASTM E 814, Standard Tors Method for Fire Test of Throughenetration Fire Stops, or ANSI/UL 1479, Standard for Fire Stops. The Director of Plant Operation Will inspect the deficient penetration for compliant fire so 1 X a week for 1 month and 1 month for 3 months. Results of these inspections we be presented by Executive Director to the QA committee further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved. The deficient practice could aff all residents while in the main dining room. Exhibit A Fire stop audit Exhibit D – Photos and other documentation Idors, exit and accesses are 7, and the means aintained free of the case of stop 18/19.2.2

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVE COMPLETED 01/10/2023			ETED		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					VILSON RD		
HAMPTC	N OAKS HEALTH	CAMPUS		SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		7 exit means of egress were			Immediate intervention		
	-	ained free of obstructions.			Part A – The two metal bench	es	
	_	ice could affect at least 30			and the loose hose on the		
	residents, as well as	staff and visitors.			sidewalk were removed.		
	E' 1' ' 1 1				Part B – The clean linen cart	on	
	Findings include:				100 hall was removed and is		
	Dogad on abassured:	ong on 01/10/22 hotyroon 11:45			stored in the laundry room.	word	
		ons on 01/10/23 between 11:45 during a tour of the facility with			Part C – The 4 rocking chairs		
	_	t Operations, Facilities			moved out of the path of egre		
		ort, and the Executive Director,			The Director of Plant Operation was educated by the Executive		
	the following was n				Director on K 211 NFPA 101		
	a. There were two metal benches and a loose				Means of Egress – General.		
	hose on the sidewalk from the 300 hall and				Aisles.		
	Services hall exit discharges to a public way at the				passageways, corridors, exits		
		exit at the rear of the facility.			discharges, exit locations and		
		loved by the Facilities			accesses are in accordance v		
	Management Suppo	-			Chapter 7, and the means of		
		n linen cart stored in the 100			egress is continuously mainta	ined	
	hall outside room 1	09. When asked, House			free of all obstructions to full u		
	Keeping person #1	said the clean linen cart was			in case of emergency, unless		
	normally stored in t	his area. House Keeping			modified by 18/19.2.2 through		
	person #1 removed	the clean linen cart from this			18/19.2.11		
	area at the time of o	bservation.			The Director of Plant Operation	ns	
	_	rocking chairs on the porch			will inspect the deficient paths		
		Room exit. Four of the rocking			egress to ensure they are free	e of	
		yay of egress to the public way			obstructions 1 X a week for 1		
		Director of Plant Operations			month and 1 x a month for 3		
		ring chairs to clear a path to			months.		
	the public way from				Results of these inspections v	vill	
		at the time of observation, the			be presented by Executive	£	
	-	perations acknowledged the			Director to the QA committee		
	_	e path of egress and said he othe path to the public way			further recommendations and		
	would move them s was clear.	o me pam to me public way			continue until the Quality		
	was cicar.				Assurance Team determines	oon	
	This finding was no	viewed with the Director of			substantial compliance has be achieved.	HII	
	_	acilities Management Support,			The deficient practice could a	ffect	
	_	Director during the exit			at least 30 residents, staff and		
	conference	meetor during the exit			visitors	4	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPI			ETED	
		155753	B. WI	NG		01/10/	2023
NAME OF B	DOLUBED OD GLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			966 N V	VILSON RD		
HAMPTO	N OAKS HEALTH	CAMPUS		SCOTT	SBURG, IN 47170		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	-	TAG			DATE
	3.1-19(b)				Exhibit A – Means of Egress audit		
	3.1 17(0)				Exhibit E – Photos and other		
					documentation		
K 0271	NFPA 101						
SS=E	Discharge from Ex						
Bldg. 01	Discharge from Ex						
		rranged in accordance with					
		rel walking surface meeting					
	-	1.1.7 with respect to					
	_	on and shall be maintained s. Additionally, the exit					
		a hard packed all-weather					
	travel surface.	a nara paokea an-weather					
	18.2.7, 19.2.7						
		on and interview, the facility	K 02	271	Compliance date –1/27/2023		01/27/2023
	failed to maintain th	ne walking surface for 1 of 8 exit			Immediate intervention		
	discharge areas fron	n the skilled care unit. This			The level change between the	2	
	_	ould affect multiple residents,			sections of the concrete walk v	was	
		visitors using the side exit			ground down so that the w		
		orridor to the Assisted Living			sections of concrete are level t	to	
	Courtyard.				eliminate the tripping hazard.		
	F' 1' ' 1 1				The Director of Plant Operation		
	Findings include:				was educated by the Executive		
	Based on observation	ons on 01/10/23 between 11:45			Director on K 271 NFPA 101 – Discharge and Exits.	-	
		during a tour of the facility with			Exit discharge is		
	_	t Operations, Facilities			arranged in accordance with 7	.7.	
		ort, and the Executive Director,			provides a level walking surface		
		exit gate from the Assisted			meeting the provisions of 7.1.7		
		lso can be used by the skilled			with respect to changes in		
	care unit) had a one	-to-two-inch level change			elevation and shall be maintair	ned	
		the concrete sidewalk to the			free of obstructions. Additional	•	
		vel change in the sections of			the exit discharge shall be a ha		
		public way could be a tripping			packed all-weather travel surfa	ace.	
		g from this area in the event of			18.2.7, 19.2.7		
		ed on interview at the time of e Facilities Management			The Director of Plant Operation	ns	
		e was a one-to-two-inch level			shall inspect the deficient sidewalk for compliance 1 X a		
	Support agreed their	e was a one-to-two-men level			Sidewalk for compliance I X a		

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

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155753	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMP	E SURVEY LETED 0/2023
	PROVIDER OR SUPPLIER ON OAKS HEALTH		966 N	ADDRESS, CITY, STATE, ZIP WILSON RD TSBURG, IN 47170	COD	
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
K 0351	the public way. This finding was re Plant Operations, Fland the Executive I conference. 3.1-19(b)	viewed with the Director of acilities Management Support, Director during the exit		week for 1 month and for 3 months. Results of these insp be presented by Exec Director to the QA corfurther recommendatic continue until the Quature Assurance Team detesubstantial compliance achieved. The deficient practice multiple residents, as and visitors using the from the entrance corresponds to the corresponding to the property of the proper	ections will cutive mmittee for ons and dity ermines e has been could affect well as staff side exit ridor to the yard. from Exits	
SS=E Bldg. 01	by construction ty throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II con protection measur substituted for spring areas where state sprinklers. In hospitals, spring clothes closets of where the area of 6 square feet and	Installation nd hospitals where required				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	01	COMPL	ETED
		155753	B. W	ING		01/10/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER	2					
LIAMOTO	N OAKS HEALTH	CAMPLIC			WILSON RD SBURG, IN 47170		
HAIVIPTC	IN OAKS HEALTH	CAMPUS		30011	SBURG, IN 47 170		
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX				COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Standard for Insta	llation of Sprinkler					
	Systems.						
	19.3.5.1, 19.3.5.2,	, 19.3.5.3, 19.3.5.4,					
	19.3.5.5, 19.4.2, 1	9.3.5.10, 9.7, 9.7.1.1(1)					
	Based on observation	on and interview, the facility	K 0	351	Compliance date -1/30/2023		01/30/2023
	failed to provide an	automatic sprinkler system			Immediate intervention		
	that provided comp	lete coverage in 1 of 6 smoke			All items stored in the 3 shows	er	
	_	s deficient practice could affect			stalls in the spa have been		
	up to 18 residents, a	as well as staff and visitors in			removed.		
	the 200 hall.				The Director of Plant Operation	ns	
					was educated by the Executiv	е	
	Findings include:				Director on K 351 NFPA 101		
	Based on observations on 01/10/23 between 11:45				Sprinkler System – Installatior	ıs.	
					Nursing homes and		
	_	during a tour of the facility with			hospitals where required by		
		t Operations and Facilities			construction type, are protecte	ed	
		ort, the 200 hall Spa was			throughout by an approved		
		d as a storage room with many			automatic sprinkler system in		
		such as, plastic totes,			accordance with NFPA 13,		
		aper, and plastic, as well as			Standard for the Installation of	f	
		ner items. This room has three			Sprinkler Systems.		
		ovided fully with sprinkler			The Director of Plant Operation		
	-	e only two sprinkler heads in			will inspect the 3 shower stalls		
		f this room that would not			the spa to ensure they are not		
		overage to all three shower			used for storage 1 X a week for	or 1	
	-	Based on interview at the time			month and 1 X a month for 3		
		Facilities Management			months.	•••	
	**	re was not enough sprinkler			Results of these inspections w	/111	
	-	ee shower stalls where			be presented by Executive	c	
	combustible materia	ai was being stored.			Director to the QA committee	ior	
	This finding was	viewed with the Director of			further recommendations and		
		acilities Management Support,			continue until the Quality Assurance Team determines		
	_	Director during the exit			substantial compliance has be	on	
	conference.	Sheetor during the exit			achieved.	C11	
	conference.				The deficient practice could at	fect	
	3.1-19(b)				up to 18 residents, as well as		
	J.1-17(U)				and visitors in the 200 hall.	stail	
					Exhibit A – Shower stall storage	no.	
					audit	y c	
					audit		

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Event ID:

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 01/10/2023	
	PROVIDER OR SUPPLIER		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				Exhibit G – Photos and other documentation	
K 0355 SS=B Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to maintain 1 in the kitchen cooking requirements of NF Portable Fire Exting 5.5.5 states fire exting protection of cooking combustible cooking oils and fats) shall be K fires. NFPA 10, placed near the extinguishing system should be accorded to the fire extinguishing system should be accorded for extinguishing portable fire extinguishing protection. This destaff in the kitchen. Findings include: Based on observation a.m. and 2:30 p.m. of the Director of Plan Management Supportable K Classes.	nguishers guishers are selected, d, and maintained in IFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility of 2 portable fire extinguishers ng area in accordance with the PA 10. NFPA 10, Standard for guishers, 2010 Edition, Section nguishers provided for the	K 0355	Compliance date – 1/10/23 Immediate intervention The Director of Plant Operation installed a placard above the kelass fire extinguisher that stat that the fire protection system shall be activated prior to using the fire extinguisher. The Director of Plant Operation was educated by the Executive Director on K 355 NFPA 101 Portable Fire Extinguishers. NFPA 10 Standard for Portable Fire Extinguishers, 20 Edition, Section 5.5.5 states fire extinguishers provided for the protection of cooking appliance using combustible cooking meshall be listed and labeled for Class K fires. NFPA 10 5.5.5.3 states a placard shall be placed near the extinguisher that state that the protection system shall be actuated prior to using the featinguisher. The Director of Plant Operation will inspect the deficient fire extinguisher for proper signage a week for 1 month and 1 X a	ced g ns e r 010 re es dia d es II

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Event ID:

Q96421

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	ILDING	01	COMPL	ETED
		155753	B. WI	NG		01/10/	2023
			<u> </u>	CTREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				VILSON RD		
HAMDTO	N OAKS HEALTH (CAMPILIS					
HAIVIPTO	IN OAKS HEALTH	CAMPUS		30011	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 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL TAG DEFICIENCY)		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	have a conspicuousl	ly placed placard near the			month for 3 months.		
	extinguisher which	states the fire protection			Results of these inspections w	ill	
	system shall be active	vated prior to using the fire			be presented by Executive		
	extinguisher. Based	d on interview at the time of			Director to the QA committee f	or	
	observation, the Dir	rector of Plant Operations said			further recommendations and		
	he had just placed th	ne K Class fire extinguisher in			continue until the Quality		
	this location and had	d not yet put up the placard.			Assurance Team determines		
		nt Operations did install the			substantial compliance has be	en	
	placard before the s	urvey had concluded.			achieved.		
					The deficient practice could af	fect	
	_	viewed with the Director of			staff in the kitchen.		
	_	acilities Management Support,			Exhibit A – Fire extinguisher		
and the Executive Director during the exit				placard audit			
	conference.				Exhibit H – Photos and other		
	2.4.40(1)				documentation		
	3.1-19(b)						
K 0374	NFPA 101						
SS=C		lding Spaces - Smoke					
Bldg. 01	Barrie	3 1					
	Subdivision of Buil	lding Spaces - Smoke					
	Barrier Doors						
	2012 EXISTING						
	Doors in smoke ba	arriers are 1-3/4-inch thick					
	solid bonded wood	d-core doors or of					
	construction that re	esists fire for 20 minutes.					
	Nonrated protectiv	e plates of unlimited height					
	are permitted. Doo	ors are permitted to have					
	fixed fire window a	assemblies per 8.5. Doors					
	are self-closing or	automatic-closing, do not					
	require latching, a	nd are not required to swing					
	in the direction of	egress travel. Door opening					
	provides a minimu	ım clear width of 32 inches					
	for swinging or ho	rizontal doors.					
	19.3.7.6, 19.3.7.8,	19.3.7.9					
	Based on observation	on and interview, the facility	K 03	374	Compliance date –1/30/2023		01/30/2023
	failed to ensure 2 of	5 sets of smoke barrier doors			Immediate intervention		
	did not have paint o	n the fire rating tags to ensure			The Director of Plant operation	ns	
		ist fire for at least 20 minutes.			contacted Lensing Architectura	al	
	LSC, Section 19.3.7	7.8 requires that doors in smoke			Sales to have the 3 smoke bar	rier	

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Facility ID: 004902

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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 <u>01</u>	(X3) DATE SURVEY COMPLETED 01/10/2023	
HAMPTO	PROVIDER OR SUPPLIER	CAMPUS	966 N \ SCOTT	ADDRESS, CITY, STATE, ZIP COD WILSON RD FSBURG, IN 47170	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	deficient practice of well as staff and vis Findings include: Based on observation a.m. and 2:30 p.m. of the Director of Plan Management Support the following was now a. Both doors in the between the 300 has covering the fire rate b. The south door in doors between the New Physical Therapy/L covering the fire rate Based on interview the Director of Plan Management Support	ons on 01/10/23 between 11:45 during a tour of the facility with t Operations, Facilities ort, and the Executive Director, oted: e set of smoke barrier doors all and Service hall had paint ing tags. In the set of smoke barrier durses' Station area and the iving Room hall had paint ing tag. at the time of observations, t Operations and Facilities ort acknowledged the paint		doors recertified and retagge ensure that they have a resis rating of at least 20 minutes. The Director of Plant Operati was educated by the Executi Director on K 374 NFPA 101 Subdivision of Building Space Smoke Barrier. Doors in smoke barrier are 1 ¾ inch thick solid bond wood-core doors or of construct that resists fire for 20 minutes LSC, section 19.3.7.8 requires that doors in smoke barriers comply with LSC Section 8.5 The Director of Plant Operati will inspect the 3 deficient do for compliance 1 x a week fo month and 1 X a month for 3 months. Results of these inspections	tance ons ve es – riers ed uction s. es shall .4 ons ors r 1
K 0511 SS=D Bldg. 01	barrier doors. This finding was re Plant Operations, Frand the Executive Econference. 3.1-19(b) NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using complies with NFF			be presented by Executive Director to the QA committee further recommendations and continue until the Quality Assurance Team determines substantial compliance has b achieved. The deficient practice could a all residents, staff and visitors Exhibit B – Smoke door audit Exhibit I – Photos and other documentation	een affect s.

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155753		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/10/2023	
	PROVIDER OR SUPPLIER ON OAKS HEALTH CAMPUS	966 N	ADDRESS, CITY, STATE, ZIP COD WILSON RD FSBURG, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility	K 0511	Compliance date -1/25/2023	01/25/2023	
	Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations, were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a	K 0511	Compliance date –1/25/2023 Immediate intervention The Director of Plant Operation replaced the receptacle near thopper with a GFCI receptacle tested for proper operation. The Director of Plant Operation was educated by the Executive Director on K 511 Utilities – General Electric. NFPA 70, NEC 2011 Edition at 210.8 Ground-Faulte Circuit-Interrupter Protection for Personnel, states, ground-faulte circuit-interruption for personnels hall be provided as required 210.8(A) through (C). NFPA 7517-20 Wet Locations, required receptacles and fixed equipments within the area of the wet location have ground-fault circuit interrupter (GFCI) protection. The Director of Plant Operation will inspect the deficient outlet GFCI protection 1 X a week for	he e and ns e as or tt el in 0, es all ent tion ns for	
	branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and		month and 1 X a month for 3 months. Results of these inspections was be presented by Executive Director to the QA committee further recommendations and		
	supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would		continue until the Quality Assurance Team determines substantial compliance has be achieved. The deficient practice could at		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155753		B. W	B. WING 01/10/2023			/2023	
		<u>l</u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					VILSON RD		
HAMPTON OAKS HEALTH CAMPUS					SBURG, IN 47170		
I IAIVIF I C	OAKO HEALITI	OAIVII OO	_	30011			_
(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	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	_	ard if power is interrupted or			1 laundry staff.		
	1 -	t is not compatible with GFCI			Exhibit B – GFCI audit		
	protection.				Exhibit J – Photos and other		
		eceptacles are installed within			documentation		
		outside edge of the sink.					
	_	(5): In industrial laboratories,					
		supply equipment where					
	•	vould introduce a greater					
		nitted to be installed without					
	GFCI protection.	/					
		(5): For receptacles located in					
	_	as of general care or critical					
		care facilities other than those					
	covered under						
		protection shall not be required.					
	(6) Indoor wet loca						
		vith associated showering					
	facilities						
		e bays, and similar areas where					
	electrical						
		ent, electrical hand tools.					
		Wet Locations, requires all					
		ed equipment within the area of					
		have ground-fault circuit					
		protection. Note: Moisture can					
		resistance of the body, and					
		is more subject to failure.					
		ice could affect one laundry					
	staff.						
	Findings in alud -						
	Findings include:						
	Raced on observation	ons on 01/10/23 between 11:45					
		during a tour of the facility with					
		at Operations and Facilities					
		ort, there was one electric					
		aree feet of the hopper sink in					
	1 -						
		nat was not provided with GFCI ested with a GFCI testing					
	_	circuit was not broken. Based					
	i device, the electric	CII CUIT WAS HOT DIOKEII. DASEU	1		l e e e e e e e e e e e e e e e e e e e		Î.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED		
155753 B. W		3. WING			01/10/2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					VILSON RD		
HAMPTO	N OAKS HEALTH (CAMPUS			SBURG, IN 47170		
T			_				
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	IX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		time of observation, the					
	-	perations and Facilities ort agreed the receptacle was					
	not properly GFCI p	-					
	not properly differ p	protected.					
	This finding was rev	viewed with the Director of					
	_	acilities Management Support,					
	•	ctor during the exit conference.					
	1	5					
	3.1-19(b)						
	1						
K 0920	NFPA 101						
SS=B		ent - Power Cords and					
Bldg. 01	Extens						
		ent - Power Cords and					
	Extension Cords						
		patient care vicinity are only					
	used for compone						
		ed electrical equipment					
	(PCREE) assembl	lified personnel and meet					
		0.2.3.6. Power strips in					
		cinity may not be used for					
	-	personal electronics),					
	, -	n care resident rooms that					
	, ,	E. Power strips for PCREE					
		UL 60601-1. Power strips					
		the patient care rooms					
) meet UL 1363. In					
	non-patient care ro	ooms, power strips meet					
	other UL standard	s. All power strips are					
	used with general	precautions. Extension					
		d as a substitute for fixed					
	_	re. Extension cords used					
		moved immediately upon					
		purpose for which it was					
		ts the conditions of 10.2.4.					
	•	9), 10.2.4 (NFPA 99), 400-8					
	, , , , , , , , , , , , , , , , , , , ,	(D) (NFPA 70), TIA 12-5		000	0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	Based on observation	on and interview, the facility	K 0	920	Compliance date – 1/10/23		01/10/2023

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STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		01	COMPLETED		
		155753	B. WI	B. WING		01/10/2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	I	
NAME OF PROVIDER OR SUPPLIER					WILSON RD		
HAMPTON OAKS HEALTH CAMPUS				SCOTT	SBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	1
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
		a power strip in 1 of 1 Physical			Immediate intervention		
		ne UL rating of 1363A or			The Director of Plant Operation	ns	
		are vicinity is defined as a			removed and disposed of the		
	_	tion intended for the			unused wheeled cart and pow		
		eatment of patients, extending 6			strip from the Physical Therap	У	
		mal location of the bed, chair,			gym.		
		other device that supports the			The Director of Plant Operation	I	
		nination and treatment. A			was educated by the Executiv	e	
	1 -	extends vertically to 7 feet 6			Director on K 920 Electrical	.	
		oor. This deficient practice			Equipment – Power Cords and	a	
	could affect residents, as well as staff in the				Extension Cords.	4	
	Physical Therapy g	ym.			Power strips in a pati	ent	
	Fig. 41				care vicinity are only used for	_ #	
	Findings include:				components of movable patie		
	D41	01/10/22 1-4 11.45			care related electrical equipme	ent	
		ons on 01/10/23 between 11:45			assembles that have been	1	
	_	during a tour of the facility with			assembled by qualified person	inei	
		t Operations, Facilities			and mee the conditions of		
		ort, and the Executive Director,			10.2.3.6. Patient care vicinity	s	
		proved power strip strapped to			defined as a space, within a		
		e Physical Therapy gym. plugged into the power strip at			location intended for the		
		tion, and Physical Therapy			examination and treatment of	and	
					patients, extending 6 feet bey		
	_	wer strip is never used. The perations removed the power			the normal location of the bed	•	
		art at the time of observation.			chair, table ,treadmill, or other device that supports the patie	I	
	sarp and wheeled c	art at the time of observation.			during examination and treatn		
	This finding was re	viewed with the Director of			A patient care vicinity extends		
	_	acilities Management Support,			vertically to 7 feet 6 inches ab		
		Director during the exit			the floor.	OVC	
	conference.	during the exit			The Director of Plant Operation	ns	
	Jointo Cinco.				will inspect for the deficient	110	
	3.1-19(b)				practice 1 X a week for 1 mon	th	
					and 1 X a month for 3 months		
					Results of these inspections w		
					be presented by Executive	'	
					Director to the QA committee	for	
					further recommendations and		
					continue until the Quality		
					Assurance Team determines		

$\label{eq:department} \textbf{DEPARTMENT OF HEALTH AND HUMAN SERVICES}$

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING <u>01</u> C		COMPL	X3) DATE SURVEY COMPLETED	
		155753	B. WING 01/10/2023				
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	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG			DATE
					substantial compliance has be achieved. The deficient practice could af residents, staff and visitors int Physical Therapy gym. Exhibit B – Electrical equipme audit Exhibit K – Photos and other documentation	fect the	

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