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	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/10/23 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 60. Quality Review completed on 01/18/23	E 0000	January 26, 2023 Hampton Oaks Health Campus 966 North Wilson Road Scottsburg, Indiana 47170 Survey Event ID Q96421. 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 20, 2023. 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	ED	02/08/2023

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.

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	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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: 01/10/23 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 all resident sleeping rooms. The facility has a capacity of 71 and had a census of 60 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 01/18/23	K 0000	January 26, 2023 Hampton Oaks Health Campus 966 North Wilson Road Scottsburg, Indiana 47170 Survey Event ID Q96421. 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 20, 2023. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0131 SS=C Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 1. Based on observation and interview, the facility failed to ensure 1 of 1 set of cross corridor fire doors in a 2-hour separation wall between the Assisted Living section of the facility and the skilled health care section of the facility did not have paint on the fire rating tags, furthermore, the facility failed to ensure 2 of 2 single fire doors in a 2-hour separation wall between the Assisted Living section of the facility and the skilled health care section of the facility closed completely and latched and were smoke and fire resistant . LSC 8.3.3.1 states openings required to have a fire protection rating of 1 1/2 hour in a 2-hour fire wall or partition shall be protected by approved, listed,	K 0131	**Compliance Date: 5/5/2023** **Part 1** **Immediate intervention** Part A – The Director of Plant Operations contacted Lensing Architectural Sales to have the two cross corridor fire doors recertified and retagged. Waiver has been requested due to potential delay of door delivery. See the re-vision of Waiver request on K131 and why waiver requested. Part B & C – The	05/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives. 8.3.3.2.2 states all products required shall bear an approved label. This deficient practice could affect all residents while in the dining room and/or adjacent egress corridor. Findings include: Based on observations on 01/10/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations, Executive Director, and Facilities Management Support, the following was noted: a. Both doors in the set of cross corridor fire doors that separates the Assisted Living section from the skilled health care section of the facility had paint on the fire rating tags. The Director of Plant Operations attempted to remove the paint at the time of observation but was unable to do so. Due to the paint on the fire rating tags, it could not be assured the doors were at least 1 1/2-hour fire rated doors. b. The single fire door between the Restorative Dining Room and the skilled care main dining room, part of the 2-hour fire separation between the Assisted living section and the skilled health care section, did not close completely and latch when tested several times. Furthermore, there was a one-half inch gap at the top of the door when closed fully. The Director of Plant Operations did adjust the door during observation so it would latch into the door frame. c. The single door between the Kitchen and the skilled care main dining room, part of the 2-hour fire separation between the Assisted living section and the skilled health care section, had a		Director of Plant Operations contacted Fitzpatrick construction to replace the doors between the restorative dining and main dining and between the kitchen and main dining rooms with new 90 minute rated fire doors that self-close, latch properly and have gaps that comply with code. Please see added note on Estimate explaining why St. Andrews Health Campus was mentioned. The Director of Plant Operations was educated by the Executive Director on K 131 NFPA 101 – Multiple Occupancies – Sections of Health Care Facilities LSC 8.3.3.1 states openings required to have a fire protection rating of 1 ½ in a 2-hour fire wall or partition shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, 8.3.3.2.2 states all products required shall bear an approved label. The Director of Plant Operations will inspect the deficient doors for closing, latching, proper labeling and gap compliance 1 X a week for 1 month and 1 X a month for 3 months. Results of these inspections will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	one-half inch gap along the bottom half of the latching side of the door when closed fully. These items were acknowledged by the Director of Plant Operations, Facilities Management Support, and the Executive Director at the time of each observation. These findings were reviewed with the Director of Plant Operations, Facilities Management Support, and the Executive Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier wall was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect all residents while in the main dining room. Findings include: Based on an observations on 01/10/23 between		be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect all residents while in the dining room and/or adjacent egress corridors. Exhibit A- 90 minute door audit Exhibit C- Other documentation photos **Part 2** Compliance date - 1/30/2023 **Immediate intervention** The Director of Plant Operations removed the unapproved expandable spray foam from the penetration in the 2-hour fire wall and filled the penetration with an approved fire stop material. The Director of Plant Operations was educated by the Executive Director on K 131 NFPA 101 – Multiple Occupancies – Sections of Health Care Facilities LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations, Facilities Management Support, and the Executive Director, there was a two-to-three-inch section of the 2-hour fire wall under a table between the kitchen and the main dining room which was not provided with approved fire stop material. The gap was filled with an unapproved expandable spray foam. This was acknowledged by the Director of Plant Operations and Facilities Management Support at the time of observation, and again during the exit conference when reviewing the expandable spray foam container. This finding was reviewed with the Director of Plant Operations, Facilities Management Support, and the Executive Director during the exit conference. 3.1-19(b)		The fire stop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Test of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests or Through-Penetration Fire Stops. The Director of Plant Operations will inspect the deficient penetration for compliant fire stop 1 X a week for 1 month and 1 X a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect all residents while in the main dining room. Exhibit A- Fire stop audit Exhibit D – Photos and other documentation	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility	K 0211	Compliance Date- 1/11/2023	01/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to ensure 3 of 7 exit means of egress were continuously maintained free of obstructions. This deficient practice could affect at least 30 residents, as well as staff and visitors. Findings include: Based on observations on 01/10/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations, Facilities Management Support, and the Executive Director, the following was noted: a. There were two metal benches and a loose hose on the sidewalk from the 300 hall and Services hall exit discharges to a public way at the maintenance room exit at the rear of the facility. These items were moved by the Facilities Management Support. b. There was a clean linen cart stored in the 100 hall outside room 109. When asked, House Keeping person #1 said the clean linen cart was normally stored in this area. House Keeping person #1 removed the clean linen cart from this area at the time of observation. c. There were eight rocking chairs on the porch outside the Living Room exit. Four of the rocking chairs were in the way of egress to the public way from this exit. The Director of Plant Operations moved the four rocking chairs to clear a path to the public way from this exit. Based on interview at the time of observation, the Director of Plant Operations acknowledged the rocking chairs in the path of egress and said he would move them so the path to the public way was clear. This finding was reviewed with the Director of Plant Operations, Facilities Management Support, and the Executive Director during the exit conference.		**Immediate intervention** Part A – The two metal benches and the loose hose on the sidewalk were removed. Part B – The clean linen cart on 100 hall was removed and is stored in the laundry room. Part C – The 4 rocking chairs were moved out of the path of egress. The Director of Plant Operations was educated by the Executive Director on K 211 NFPA 101 - Means of Egress – General. Aisles, passageways, corridors, exits discharges, exit locations and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11 The Director of Plant Operations will inspect the deficient paths of egress to ensure they are free of obstructions 1 X a week for 1 month and 1 x a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect at least 30 residents, staff and visitors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)		Exhibit A – Means of Egress audit Exhibit E – Photos and other documentation	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain the walking surface for 1 of 8 exit discharge areas from the skilled care unit. This deficient practice could affect multiple residents, as well as staff and visitors using the side exit from the entrance corridor to the Assisted Living Courtyard. Findings include: Based on observations on 01/10/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations, Facilities Management Support, and the Executive Director, the sidewalk at the exit gate from the Assisted Living Courtyard (also can be used by the skilled care unit) had a one-to-two-inch level change between sections of the concrete sidewalk to the public way. The level change in the sections of the sidewalk to the public way could be a tripping hazard while exiting from this area in the event of an emergency. Based on interview at the time of each observation, the Facilities Management Support agreed there was a one-to-two-inch level	K 0271	Compliance date –1/27/2023 **Immediate intervention** The level change between the 2 sections of the concrete walk was ground down so that the w sections of concrete are level to eliminate the tripping hazard. The Director of Plant Operations was educated by the Executive Director on K 271 NFPA 101 – Discharge and Exits. Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 The Director of Plant Operations shall inspect the deficient sidewalk for compliance 1 X a	01/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	change in the sections of the concrete sidewalk to the public way. This finding was reviewed with the Director of Plant Operations, Facilities Management Support, and the Executive Director during the exit conference. 3.1-19(b)		week for 1 month and 1 X a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect multiple residents, as well as staff and visitors using the side exit from the entrance corridor to the Assisted Living Courtyard. Exhibit A – Discharge from Exits audit Exhibit F – Photos and other documentation	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Standard for Installation 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, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 6 smoke compartments. This deficient practice could affect up to 18 residents, as well as staff and visitors in the 200 hall. Findings include: Based on observations on 01/10/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations and Facilities Management Support, the 200 hall Spa was currently being used as a storage room with many combustible items, such as, plastic totes, cardboard boxes, paper, and plastic, as well as wheelchairs and other items. This room has three shower stalls not provided fully with sprinkler coverage. There are only two sprinkler heads in the center portion of this room that would not provide sprinkler coverage to all three shower stalls if necessary. Based on interview at the time of observation, the Facilities Management Support agreed there was not enough sprinkler coverage in the three shower stalls where combustible material was being stored. This finding was reviewed with the Director of Plant Operations, Facilities Management Support, and the Executive Director during the exit conference. 3.1-19(b)	K 0351	Compliance date –1/30/2023 **Immediate intervention** All items stored in the 3 shower stalls in the spa have been removed. The Director of Plant Operations was educated by the Executive Director on K 351 NFPA 101 Sprinkler System – Installations. Nursing homes and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. The Director of Plant Operations will inspect the 3 shower stalls in the spa to ensure they are not used for storage 1 X a week for 1 month and 1 X a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect up to 18 residents, as well as staff and visitors in the 200 hall. Exhibit A – Shower stall storage audit	01/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Exhibit G – Photos and other documentation	
K 0355 SS=B Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 5.5.5 states fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 5.5.5.3 states a placard shall be placed near the extinguisher that states that the protection system shall be actuated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using the portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect staff in the kitchen. Findings include: Based on observations on 01/10/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations, Facilities Management Support, and the Executive Director, the portable K Class fire extinguisher located near the three-compartment sink in the kitchen did not	K 0355	Compliance date – 1/10/23 **Immediate intervention** The Director of Plant Operations installed a placard above the K class fire extinguisher that stated that the fire protection system shall be activated prior to using the fire extinguisher. The Director of Plant Operations was educated by the Executive Director on K 355 NFPA 101 Portable Fire Extinguishers. NFPA 10 Standard for Portable Fire Extinguishers, 2010 Edition, Section 5.5.5 states fire extinguishers provided for the protection of cooking appliances using combustible cooking media shall be listed and labeled for Class K fires. NFPA 10 5.5.5.3 states a placard shall be placed near the extinguisher that states that the protection system shall be actuated prior to using the fire extinguisher. The Director of Plant Operations will inspect the deficient fire extinguisher for proper signage 1 X a week for 1 month and 1 X a	01/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	have a conspicuously placed placard near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of observation, the Director of Plant Operations said he had just placed the K Class fire extinguisher in this location and had not yet put up the placard. The Director of Plant Operations did install the placard before the survey had concluded. This finding was reviewed with the Director of Plant Operations, Facilities Management Support, and the Executive Director during the exit conference. 3.1-19(b)		month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect staff in the kitchen. Exhibit A – Fire extinguisher placard audit Exhibit H – Photos and other documentation	
K 0374 SS=C 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. 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 2 of 5 sets of smoke barrier doors did not have paint on the fire rating tags to ensure the doors would resist fire for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke	K 0374	Compliance date –1/30/2023 **Immediate intervention** The Director of Plant operations contacted Lensing Architectural Sales to have the 3 smoke barrier	01/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	barriers shall comply with LSC, Section 8.5.4. This deficient practice could affect up all residents, as well as staff and visitors. Findings include: Based on observations on 01/10/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations, Facilities Management Support, and the Executive Director, the following was noted: a. Both doors in the set of smoke barrier doors between the 300 hall and Service hall had paint covering the fire rating tags. b. The south door in the set of smoke barrier doors between the Nurses' Station area and the Physical Therapy/Living Room hall had paint covering the fire rating tag. Based on interview at the time of observations, the Director of Plant Operations and Facilities Management Support acknowledged the paint covering the fire rating tags on the sets of smoke barrier doors. This finding was reviewed with the Director of Plant Operations, Facilities Management Support, and the Executive Director during the exit conference. 3.1-19(b)		doors recertified and retagged to ensure that they have a resistance rating of at least 20 minutes. The Director of Plant Operations was educated by the Executive Director on K 374 NFPA 101 Subdivision of Building Spaces – Smoke Barrier. Doors in smoke barriers are 1 ¾ inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. LSC, section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC Section 8.5.4 The Director of Plant Operations will inspect the 3 deficient doors for compliance 1 x a week for 1 month and 1 X a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect all residents, staff and visitors. Exhibit B – Smoke door audit Exhibit I – Photos and other documentation	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 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 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 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	K 0511	Compliance date –1/25/2023 **Immediate intervention** The Director of Plant Operations replaced the receptacle near the hopper with a GFCI receptacle and tested for proper operation. The Director of Plant Operations was educated by the Executive Director on K 511 Utilities – Gas and Electric. 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). NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. The Director of Plant Operations will inspect the deficient outlet for GFCI protection 1 X a week for 1 month and 1 X a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect	01/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect one laundry staff. Findings include: Based on observations on 01/10/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations and Facilities Management Support, there was one electric receptacle within three feet of the hopper sink in the laundry room that was not provided with GFCI protection. When tested with a GFCI testing device, the electric circuit was not broken. Based		1 laundry staff. Exhibit B – GFCI audit Exhibit J – Photos and other documentation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on interview at the time of observation, the Director of Plant Operations and Facilities Management Support agreed the receptacle was not properly GFCI protected. This finding was reviewed with the Director of Plant Operations, Facilities Management Support, and Executive Director during the exit conference. 3.1-19(b)			
K 0920 SS=B Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility	K 0920	Compliance date – 1/10/23	01/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to an ensure a power strip in 1 of 1 Physical Therapy gym met the UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice could affect residents, as well as staff in the Physical Therapy gym. Findings include: Based on observations on 01/10/23 between 11:45 a.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations, Facilities Management Support, and the Executive Director, there was a non-approved power strip strapped to a wheeled cart in the Physical Therapy gym. There was nothing plugged into the power strip at the time of observation, and Physical Therapy staff #1 said the power strip is never used. The Director of Plant Operations removed the power strip and wheeled cart at the time of observation. This finding was reviewed with the Director of Plant Operations, Facilities Management Support, and the Executive Director during the exit conference. 3.1-19(b)		**Immediate intervention** The Director of Plant Operations removed and disposed of the unused wheeled cart and power strip from the Physical Therapy gym. The Director of Plant Operations was educated by the Executive Director on K 920 Electrical Equipment – Power Cords and Extension Cords. Power strips in a patient care vicinity are only used for components of movable patient care related electrical equipment assembles that have been assembled by qualified personnel and mee the conditions of 10.2.3.6. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table ,treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. The Director of Plant Operations will inspect for the deficient practice 1 X a week for 1 month and 1 X a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 01 B. WING	01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			substantial compliance has been achieved. The deficient practice could affect residents, staff and visitors int the Physical Therapy gym. Exhibit B – Electrical equipment audit Exhibit K – Photos and other documentation	