

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

PRINTED: 07/17/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING	X3) DATE SURVEY COMPLETED 06/26/2023
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NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP COD 1143 23RD ST TELL CITY, IN 47586
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E 0000 Bldg. --	<p>A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 04/26/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 06/26/23</p> <p>Facility Number: 002512 Provider Number: 155671 AIM Number: 200278620</p> <p>At this PSR to the Emergency Preparedness survey, Oakwood Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has a capacity of 98 certified beds and had a census of 79 at the time of this visit.</p> <p>Quality Review completed on 06/27/23</p>	E 0000	The submission of this plan of correction does not indicate an admission by Oakwood Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Oakwood Health Campus. The facility recognizes 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 skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/26/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p>	K 0000	The submission of this plan of correction does not indicate an admission by Oakwood Health Campus that the findings and allegations contained herein are	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary C. Blocker	Executive Director	07/12/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0222 SS=E Bldg. 01	<p>Survey Date: 06/26/23</p> <p>Facility Number: 002512 Provider Number: 155671 AIM Number: 200278690</p> <p>At this PSR survey, Oakwood 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.</p> <p>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 98 and had a census of 79 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 06/27/23</p> <p>NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING</p>		<p>accurate, true representation of the quality of care provided, and living environment provided to the residents of Oakwood Health Campus. The facility recognizes 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 skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.</p>		

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	<p>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS</p> <p>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p>DELAYED-EGRESS LOCKING ARRANGEMENTS</p> <p>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS</p>			

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	<p>LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4</p> <p>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:</p> <p>(a) The force shall not be required to exceed 15 lbf (67 N).</p> <p>(b) The force shall not be required to be continuously applied for more than 3 seconds.</p> <p>(c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.</p> <p>(d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect mostly staff, plus any residents, as well as staff and visitors while in the service hall.</p> <p>Findings include:</p>	K 0222	<p>K 222 Egress Doors</p> <p><i>This Requirement is not met as evidenced by the facility failed to ensure the means of egress through all delayed egress locks was readily accessible for all residents, staff, and visitors. No signage was available that states "Push until alarm sounds. Door can be opened in 15 seconds.</i></p> <p>- 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</p> <p>-The Director of Plant Operations was educated on 5/16/2023 by the Executive Director on NFPA 101-2012 edition sections; 19.2.2.2, 7.2.1.5.10, and 7.2.1.6. -The Director of Plant</p>	08/25/2023
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	<p>Based on observations on 06/26/23 between 10:00 a.m. and 11:00 a.m. during a tour of the facility with the Director of Plant Operations, the Service Hall exit door across from the courtyard door was equipped with delayed egress. When the panic bar on the door was pushed for 15 seconds several times the door did not release from the magnetic hold located at the top of the door. However, the magnetic hold did release the door when the code was pushed on the keypad located next to the door. Based on interview at the time of observation, the Director of Plant Operations said the facility has ordered an entire new exit door and frame and is waiting for it to come in for replacement.</p> <p>This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference.</p> <p>This deficient practice was cited on 04/26/23. The facility failed to implement proper corrective action.</p> <p>3.1-19(b)</p>		<p>Operations has contacted the vendor to repair the service hall door across from the courtyard door on 5/19/2023 with quote to follow.</p> <ul style="list-style-type: none"> -Education provided to staff on door code and EOP evacuation routes on 5/17/2023. -Vendor contacted for update of repairs on 7/6/2023 and lead time for supplies arrival was 4-6 weeks estimated. <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <ul style="list-style-type: none"> -No residents were affected, but all have the potential to be affected. <p>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> -DPO or designee will complete weekly rounds to ensure proper functioning all surrounding doors. -DPO or designee will complete weekly rounds to affected door to ensure code and fire alarm release is still functioning. <p>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance</p>	

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			<p>program will be put into place?</p> <ul style="list-style-type: none"> -DPO or designee will complete weekly rounds times 4 weeks. Then every other week weeks 4 weeks. Then monthly. -For quality assurance, the DPO or designee will review any findings and subsequent corrective action quarterly for at least six months in the campus quality assurance meetings (QAPI). Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this regulation. <p>5. Date of completion: 8/25/2023</p>		