STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155782	A. BUILDING 00 B. WING	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WHITE OAK HEALTH CAMPUS	814 S 6TH ST MONTICELLO, IN 47960

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and the Investigation of Residential Complaint IN00395469. Complaint IN00395469 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 23, 24, 25, 26, 27 and 30, 2023. Facility number: 012355 Provider number: 155782 AIM number: 201014410 Census Bed Type: SNF/NF: 29 SNF: 28 Residential: 55 Total: 112 Census Payor Type: Medicare: 17 Medicaid: 29 Other: 11 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/1/23.	F 0000	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of White Oak 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.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Anderson	Executive Director	02/10/2023

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.

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	The assessment must accurately reflect the resident's status. Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to oxygen use for 1 of 15 MDS assessments reviewed. (Resident 12) Finding includes: On 1/24/23 at 10:09 a.m., Resident 12 was observed seated in her room. She was wearing a nasal cannula and oxygen was flowing at 2 liters per minute (lpm) via an oxygen concentrator. The resident's record was reviewed on 1/24/23 at 3:00 p.m. The resident was hospitalized and readmitted to the facility on 1/6/23. Diagnoses included, but were not limited to, acute respiratory failure and sepsis. The Admission MDS, dated 1/11/23, indicated the resident did not use oxygen 14 days prior to being in the facility or since being admitted to the facility. There was no Physician's order for oxygen. An Admission Observation, dated 1/6/23, indicated the resident was using oxygen at 1 lpm. A Vital's Note, dated 1/7/23, indicated the resident was using oxygen at 2 lpm. A Vital's Note, dated 1/8/23, indicated the resident was using oxygen at 2 lpm. Interview with MDS Nurse on 1/25/23 at 2:13 p.m., indicated she did not code for oxygen because	F 0641	1) Resident 12 was not affected by the deficient practice. The MDS Assessment was revised to indicate that the resident did wear oxygen. 2) All residents that wear oxygen have the potential to be affected. An audit of all residents that wear oxygen was completed to ensure that their MDS assessment was reflective of such. 3) The MDS Nurse was educated on the importance of and requirement of physically assessing all residents prior to completion of their MDS for accuracy. The DHS or designee will audit 5 MDS Assessments for accuracy 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months. 4) Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meetings as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5) 2/17/2023	02/17/2023

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	she didn't know the resident was on oxygen when she was admitted. She only used information in the Physician's Orders, she did not go and physically assess the resident to see if there was oxygen in use. 3.1-31(i)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to assess and monitor wounds that required treatment changes and failed to provide treatment as ordered during wound care for 1 of 5 residents reviewed for pressure ulcers. (Resident 12) Findings include: 1. On 1/24/23 at 10:09 a.m., Resident 12 was observed seated in her room in a recliner. She indicated she had sores on her bottom that were uncomfortable and the nurses were doing treatments to them. On 1/27/23 at 8:45 a.m., the resident's wound care was observed with LPN 2. There were two open areas on the right buttocks, each approximately 1.5 centimeter (cm) x 1 cm, one on the left buttock approximately 2 cm x 1 cm and the coccyx	F 0684	1) Resident 12's treatment was redone immediately and observed by Nursing Management to have been done correctly after education with LPN 2. Resident 12's wounds were assessed and documented appropriately by the facility wound nurse and improvement is noted. Appropriate treatment remains in place for resident's wounds. 2) All resident's with wounds have the potential to be affected. A skin assessment of all residents with wounds has been completed by the wound nurse and no new skin areas were identified. 3) Nursing staff were in-serviced by the DHS on the accuracy of wound treatments. The wound	02/17/2023

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	approximately 0.5 cm x 0.5 cm. The resident's record was reviewed on 1/24/23 at 3:00 p.m. The resident had been hospitalized and readmitted on 1/6/23. Diagnoses included, but were not limited to, C.diff. (clostridium difficile, an infectious intestinal disease that causes loose stools) and sepsis. The Admission Minimum Data Set assessment, dated 1/11/23, indicated the resident was admitted with 2 unstageable pressure ulcers. A Progress Note, dated 1/7/23, indicated resident had been readmitted from hospital with a pressure ulcer to left buttock measuring 4 centimeters (cm) x 2 cm, and right buttock 6 cm x 3 cm. A Progress Note, dated 1/12/23, was entered by the Wound Nurse. The right buttock measured 3 cm x 1.5 cm and the left buttock was 1.5 x 1 cm. Because the wounds were not on a bony prominence, and on the fatty portion of the buttock and the resident was having frequent loose stools, the wounds would not be classified as pressure, but as MASD (moisture-associated skin damage). A Progress Note, dated 1/15/23, indicated wounds to fatty portion of buttocks remained. Treatment in place with frequent dressing changes due to frequent loose stools. There was a new open area to the resident's coccyx. There were no measurements or assessment of the new area to the coccyx. There were no additional measurements of the right or left buttocks in progress notes. A Physician's Order, dated 1/7/23, indicated to		nurse was provided additional education on appropriate documentation including evaluating the wounds and charting the reason any treatments are changed. The DHS or designee will complete rounds of 5 residents with wound treatments a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months to ensure that the physician ordered treatments are being completed accurately. 4) Ongoing compliance with this corrective action will occur as the DHS and/or designee will present the audits at the monthly QAPI meetings as facilitated by the Executive Director; audits will be discontinued after six months if no further concerns are identified. 5) 2/17/2023	

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	apply Medihoney and foam dressing to right and left buttocks every three days. A Physician's Order, dated 1/14/23, indicated to cleanse right and left buttock with would cleanser or normal saline, apply skin prep around the wound, apply calcium alginate to wound bed and cover with foam dressing every three days and as needed. A Physician's Order, dated 1/15/23, for coccyx was to cleanse with wound wash or normal saline, apply skin prep around wound and apply foam dressing every three days A Physician's Order, dated 1/25/23, indicated to to cleanse coccyx, right and left buttock with wound wash or normal saline, apply skin prep around wounds, apply collagen to wound beds and cover with foam dressing every three days and as needed. There was no indication in the progress notes as to why the treatments had been changed, or if the wounds had improved or worsened. Interview with Nurse Consultant 1 on 1/26/23 at 12:57 p.m., indicated if a wound wasn't pressure it did not require it to be monitored in wound rounds or measured weekly. It would be monitored by nursing staff and the Wound Nurse would assess it weekly. Consistent nursing staffing was planned to monitor improvement or worsening. The wounds were being considered moisture associated skin damage (MASD). Interview with LPN 2 on 1/27/23 at 9:15 a.m., indicated she was unsure if there had been two open areas on the resident's right buttock before, one of the areas might be new, it had been about a			

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	week since she had last observed the wounds. She indicated the resident no longer had C.diff or loose stools. 2. On 1/27/23 at 8:45 a.m., Resident 12's wound care was observed with LPN 2. There were two open areas on the right buttocks, each approximately 1.5 cm x 1 cm, one on the left buttock approximately 2 cm x 1 cm and the coccyx approximately 0.5 cm x 0.5 cm. The LPN cleansed the area with wound wash and patted gently with gauze. She then applied a piece of collagen to the open area on the left buttock. She then covered the entire area with a large foam dressing. A Physician's Order, dated 1/25/23, indicated to to cleanse coccyx, right and left buttock with wound wash or normal saline, apply skin prep around wounds, apply collagen to all wound beds and cover with foam dressing every three days and as needed. Interview with the LPN, on 1/27/23 at 9:15 a.m., indicated she was not aware she had done the treatment incorrectly and she would re-do it. 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and			

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	483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure a Physician Order was in place for a resident receiving oxygen for 1 of 1 residents reviewed for respiratory care. (Resident 12) Finding includes: On 1/24/23 at 10:09 a.m., Resident 12 was observed seated in her room. She had a nasal cannula in place and oxygen was flowing at 2 liters per minute (lpm) via oxygen concentrator. The resident's record was reviewed on 1/24/23 at 3:00 p.m. Diagnoses included, but were not limited to, acute respiratory failure and sepsis. There was no Physician's Order for oxygen. A Respiratory Care Plan, dated 1/17/23, indicated the resident had the potential for shortness of breath when laying flat due to respiratory failure. Interview with LPN 1 on 1/25/23 at 9:45 a.m., indicated she was unable to locate a Physician's Order for oxygen and would contact the physician to clarify. 3.1-37(a)(6)	F 0695	1) Resident 12 had no adverse effects as a result of the deficient practice. Residents physician was notified and a physicians order was obtained for her oxygen. 2) All other residents that wear oxygen have the potential to be affected by the same deficient practice. An audit of all other residents that wear oxygen in the facility was completed to ensure that they have a corresponding physicians order in place. 3) Nursing staff educated on ensuring that a physicians order is obtained if a resident returns from the hospital on oxygen or if a resident is newly put on oxygen. The DHS or designee will complete audits to ensure that all residents that are wearing oxygen have appropriate corresponding oxygen orders 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months. 4) Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meetings as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5) 2/17/202	02/17/2023
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	This visit was for a State Residential Licensure Survey and the Investigation of Residential Complaint IN00395469. This visit included a Recertification and State Licensure Survey. Complaint IN00395469 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 23, 24, 25, 26, 27 and 30, 2023. Facility number: 012355 Residential Census: 55 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/1/23.	R 0000	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of White Oak 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.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status.			

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	(2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review, and interview, the facility failed to ensure a resident was assessed for the ability to self-administer medications for 1 of 5 residents observed during medication pass. (Resident 9) Finding includes: On 1/30/23 at 3:25 p.m., LPN 3 was observed preparing Resident 9's medications, which included Vitamin D3 and Lexapro (escitalopram, an antidepressant medication). She brought the medications to Resident 9's room and entered the room. Resident 9 indicated to leave the medications on the table near her. LPN 3 set down the medications where Resident 9 had requested and exited the room. Interview with LPN 3 on 1/30/23 at 3:27 p.m., indicated the resident was able to self-administer her medications. The record for Resident 9 was reviewed on 1/30/23 at 3:55 p.m. Diagnoses included, but were not limited to, fibrous dysplasia and anxiety disorder. A Service Plan, dated 12/16/22, indicated the resident required assistance to administer medications and staff was to provide the medications. There was lack of documentation of any	R 0216	1) Resident 9 was noted to have no adverse effects related to the deficient practice. Interview with Resident 9 approximately 20 minutes after medication pass revealed that resident had taken the medications. 2) All residents that reside in the Assisted Living and have physician orders for medications to be administered by the facility staff have the potential to be affected by the deficient practice. All residents that prefer to have their medications left at their bedside were reviewed to ensure that physicians orders and assessments were in place. 3) Nurse's and QMA's were educated on following physician orders during medication pass including if the medications must be administered by staff, if they could be left at bedside or if a resident could self-administer. The DHS and/or designee will complete medication administration observations for ten residents every week for 4 weeks, ten residents every other week for 4 weeks, and then ten residents weekly for 4 months and present	02/17/2023

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	Physician's Order or assessment for self-administration of medications. Interview with the Director of Nursing and the Administrator on 1/30/23 at 4:11 p.m., indicated the resident was not to self-administer medications and the Nurse should not have left the medications with the resident. A Facility policy, titled "AL-Self Administration of Medication Guidelines", received as current, indicated "...1. Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed for safety by a licensed nurse. 2. Results of the assessment will be presented to the physician for evaluation and an order for self-medication. a. The order should include the type of medications the resident is able to self-medicate..."		any concerns at the monthly QAPI meeting. 4) Ongoing compliance with this correction action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5) 2/17/2023	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be			

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	signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure an Initial Service Plan was completed on admission for 1 of 5 current resident records reviewed. (Resident 4) Finding includes: Resident 4's record was reviewed on 1/27/23 at 3:22 p.m. The resident was admitted to the memory care unit on 9/30/22. The Initial Service Plan was dated 12/20/22. Interview with the Memory Care Director on 1/30/23 at 11:33 a.m., indicated that was the first service plan completed, the family had been hard to contact and it was overlooked.	R 0217	1) Resident 4 was not affected by the deficient practice. His service plan remains current that was completed on 12/20/2022. 2) All residents residing on the Legacy Assisted Living Unit have the potential to be affected. An audit of all service plans on the Legacy Unit has been completed and no new concerns were identified. 3)As a measure of ongoing compliance, the Executive Director and/or designee will audit service plan completion on 5 residents weekly for 4 weeks, every other week for 2 months and then monthly for 3 months and present any concerns at the monthly QAPI meeting. 4) Ongoing compliance with this correction action plan will occur as the Executive Director and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no	02/17/2023

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			further concerns are identified. 5) 2/17/2023	