

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155782	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/12/2024
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NAME OF PROVIDER OR SUPPLIER  WHITE OAK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: February 5, 6, 7, 8, 9, and 12, 2024.</p> <p>Facility number: 012355 Provider number: 155782 AIM number: 201014410</p> <p>Census Bed Type: SNF/NF: 27 SNF: 31 Residential: 60 Total: 118</p> <p>Census Payor Type: Medicare: 18 Medicaid: 21 Other: 19 Total: 58</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on 2/15/24.</p>	F 0000		
F 0550 SS=D Bldg. 00	<p>483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Anderson	Executive Director	03/01/2024

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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	<p>resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained, related to not placing a dignity bag over a foley (urinary) catheter drainage bag, for 1 of 1 residents reviewed for urinary catheters. (Resident 40)</p>	F 0550	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	03/01/2024

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	<p>Finding includes:</p> <p>On 2/7/24 at 10:55 a.m., Resident 40 was observed in his room in bed. His catheter drainage bag was observed uncovered and draining yellow urine by gravity.</p> <p>On 2/7/24 at 11:26 a.m., Resident 40's catheter drainage bag was observed uncovered and draining yellow urine by gravity.</p> <p>Resident 40's record was reviewed on 2/7/24 at 10:28 a.m. Diagnoses included, but were not limited to, Parkinson's disease, hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction affecting the right dominant side, and obstructive uropathy (obstruction causing a blockage of the flow of urine.)</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 1/18/24, indicated the resident was cognitively intact for daily decision making. He had an indwelling urinary catheter.</p> <p>A Physician's Order, dated 1/11/24, indicated indwelling urinary catheter size 16 french with a 5 cc balloon.</p> <p>A Care Plan, dated 1/21/24, indicated the resident used a foley catheter. Interventions included, but were not limited to, maintain a closed system with urinary bag below the resident's bladder and cover.</p> <p>During an interview on 2/7/24 at 11:26 a.m., RN 1 indicated the catheter bag should have had a dignity bag over it.</p> <p>During an interview on 2/8/24 at 2:52 p.m., the Director of Nursing (DON) indicated the catheter</p>		<p>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.</p> <p>1 1)Resident 40 had the potential to be affected by alleged deficient practice. No adverse effects have been noted from the alleged deficient practice.</p> <p>2 2)All residents residing in the facility with catheters have the potential to be affected. A review of all residents with catheter bags was completed on 2/22/2024 with no additional residents identified.</p> <p>3 3)ED educated all staff on the importance of ensuring each resident's dignity by ensuring that dignity bags are over every catheter bag. The DHS and/or designee will complete audits for all residents with a catheter ensuring that catheter bags are</p>	
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F 0554 SS=D Bldg. 00	<p>bag should have been covered with a dignity bag.</p> <p>3.1-3(t)</p> <p>483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for self-administration of medication,s and an assessment to self-administer their own medications, for 2 of 2 residents reviewed for self-administration of medication. (Residents 13 and 19)</p> <p>Findings include:</p> <p>1. On 2/5/24 at 11:11 a.m., a bottle of Tylenol 325 milligram (mg) tablets was noted to be on Resident 13's bedside table.</p> <p>On 2/5/24 at 2:51 p.m., a bottle of Tylenol 325 mg tablets was noted to be on Resident 13's bedside table.</p>	F 0554	<p>covered 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks, and then monthly for 3 months.</p> <p>4 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.</p> <p>5 5)The systemic changes or this deficiency will be completed by March 1, 2024.</p> <p><b><u>F554 Resident Self-Admin Meds- Clinically Appropriate</u></b> 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</p>	03/01/2024	

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	<p>The record for Resident 13 was reviewed on 2/7/24 at 12:37 p.m. Diagnoses included, but were not limited to, vascular dementia without behavioral disturbance.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 1/5/24, indicated the resident was moderately impaired for daily decision making.</p> <p>A Physician's Order, dated 5/30/23, indicated acetaminophen tablet 325 milligrams, 2 tablets for fever/pain every 4 hours as needed.</p> <p>There were no orders for self-administration or a self-administration assessment completed for the medication.</p> <p>During an interview on 2/7/24 at 11:23 a.m., QMA 1 indicated the resident came from assisted living, and it was a constant battle to keep her medications in the drawer.</p> <p>During an interview on 2/7/24 at 11:37 a.m., RN 1 indicated the resident did have a bottle of Tylenol sitting on her bedside table that morning. She did not have orders to self-administer the medication.</p> <p>During an interview on 2/8/23 at 2:55 p.m., the Administrator indicated she was going to provide the family education on medications at the bedside, as they continuously visited and she believed they had brought the bottle of Tylenol.</p> <p>2. On 2/5/24 at 11:36 a.m., an albuterol inhaler was observed on the Resident 19's bedside table. The resident indicated she had been taking it herself as needed.</p>		<p>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> <p>1 1)Resident's 13 and 19 had the potential to be affected by alleged deficient practice. The Tylenol from Resident 13's room was immediately removed and a Resident First meeting was held with resident's POA and policy was explained and he expressed an understanding. Resident 19's Self-Administration Assessment was immediately deeming that she is appropriate to self-administer her inhaler.</p> <p>2 2)All residents have the potential to be affected. All residents that self-administer medications were reviewed to ensure that their assessments are correct.</p> <p>3 3)DHS educated nurse's on ensuring that self-administer assessments are current and only residents that have a self-administration assessment deeming that they are safe are permitted to have medications at</p>	

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	<p>On 2/5/24 at 12:09 p.m., an albuterol inhaler was observed on Resident 19's bedside table.</p> <p>The record for Resident 19 was reviewed on 2/7/24 at 2:01 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and chronic bronchitis.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 1/25/24, indicated the resident was cognitively intact for daily decision making. She had shortness of breath with exertion and when lying flat. She also used oxygen therapy.</p> <p>A Physician's Order, dated 11/20/23, indicated albuterol sulfate aerosol inhaler 90 micrograms/actuation, two puffs as needed every four hours, for shortness of breath and wheezing. May keep at bedside.</p> <p>The Self-Administration of Medication Assessment, dated 8/26/23 at 2:31 a.m., indicated the resident did not want to self-administer medications. The facility would set-up medications for the resident.</p> <p>During an interview on 2/7/24 at 11:39 a.m., RN 1 indicated the resident used to take her albuterol inhaler with her when she went on facility outings, and recently started self-administering while in the facility.</p> <p>During an interview on 2/8/24 at 2:51 p.m., the Director of Nursing indicated the resident had a self-administration assessment completed in 2022 which indicated she was going to self-administer the medication, however, the most recent self-administration assessment did not indicate she was going to self-administer any medications.</p>		<p>bedside. The DHS and/or designee will complete audits of resident rooms ensuring that all residents with medications at bedside have a completed observation 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks, and then monthly for 3 months.</p> <p>4 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.</p> <p>5 5)The systemic changes or this deficiency will be completed by March 1, 2024.</p>	

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F 0641 SS=A Bldg. 00	<p>3.1-11(a)</p> <p>483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately completed, related to hospice services coded incorrectly, for 1 of 19 MDS assessments reviewed. (Resident 27)</p> <p>Finding includes:</p> <p>Record review for Resident 27 was completed on 2/8/24 at 12:10 p.m. Diagnoses included, but were not limited to, hypertension and dementia.</p> <p>The Quarterly MDS assessment, dated 12/14/23, indicated the resident was cognitively moderately impaired. The resident had received hospice services.</p> <p>The record lacked any documentation to indicate the resident had received the hospice services.</p> <p>During an interview on 2/9/24 at 11:24 a.m., the MDS Coordinator indicated the resident did not receive hospice services, and the MDS was coded incorrectly.</p>	F 0641	Citation at an A level Scope and Severity. No POC required	03/01/2024
F 0684 SS=D Bldg. 00	<p>3.1-31(d)(3)</p> <p>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</p>			

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	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure skin odors and discolorations were assessed, monitored, and treated, for 1 of 3 residents reviewed for skin conditions (non-pressure related). (Resident 19)</p> <p>Finding includes:</p> <p>During an interview on 2/5/24 at 11:42 a.m., Resident 19 indicated she had an area of skin underneath her breasts that had a foul odor "for a while" and was itchy. She was unable to see if it was reddened, and indicated the facility staff were not treating the area. She was observed scratching the area and a foul odor was noted when the resident lifted her breast.</p> <p>The record for Resident 19 was reviewed on 2/7/24 at 2:01 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and chronic bronchitis.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 1/25/24, indicated the resident was cognitively intact for daily decision making. She had no pressure sores or skin conditions.</p> <p>There were no orders for a treatment or any documentation in the record related to the skin area under the breasts.</p> <p>The February 2024 Physician's Order Summary</p>	F 0684	<p>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.</p> <p>1 1)Resident 19 had the potential to be affected by deficient practice. The resident was immediately assessed by a</p>	03/01/2024
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R 0000  Bldg. 00	<p>(POS), indicated a weekly skin assessment every Thursday.</p> <p>The Weekly Skin Assessment completed for February 2024, on the Treatment Administration Record, indicated the resident had no skin impairments noted on 2/1/24 or 2/8/24.</p> <p>During an interview on 2/8/24 at 3:50 p.m., the Director of Nursing indicated they were unaware of the skin condition, but she had the wound nurse assess the area. There was a reddened area of skin under her breasts and they were getting orders to treat the area with a powder.</p> <p>3.1-37(a)</p> <p>This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.</p> <p>Survey dates: February 5, 6, 7, 8, 9, and 12, 2024.</p>	R 0000	<p>licensed nurse and treatment was initiated. Resident's skin condition has healed without any concern.</p> <p>2 2)All residents have the potential to be affected. A skin sweep was completed on all residents to identify any unaccounted-for skin issues.</p> <p>3 3)DHS educated all nursing staff on the accuracy of skin assessments and ensuring that treatments are in place for all skin concerns. The DHS and/or designee will complete audits of resident skin 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.</p> <p>4 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.</p> <p>5)The systemic changes or this deficiency will be completed by March 1, 2024.</p>	

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R 0407 Bldg. 00	<p>Facility number: 012355</p> <p>Residential Census: 60</p> <p>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on 2/15/24.</p> <p>410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control guidelines were in place and implemented, related to not wearing gloves while administering an injectable medication, for 1 of 5 residents observed during medication administration. (Resident 3, LPN 1)</p> <p>Finding includes:  On 2/12/24 at 11:16 a.m., LPN 1 was observed preparing Resident 3's medication. The LPN had drawn up 3 units of insulin in a syringe. The LPN then wiped the resident's abdomen with an alcohol prep pad, and injected the insulin into the</p>	R 0407	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	03/01/2024

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	<p>resident's abdomen. The LPN was not wearing gloves when she administered the insulin with the syringe. The LPN indicated, she normally would put on gloves before administering injectable medications, but forgot to put them on.</p> <p>A facility policy titled, "Specific Medication Administration Procedures" and received as current from the Director Of Nursing on 2/12/24, indicated..."Injectable Medication Administration...Equipment Required...E. Examination gloves..."</p>		<p>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> <p>1 1)Resident was not affected by the deficient practice. 2 2)All residents have the potential to be affected by the deficient practice. 3 3)DHS educated all nursing staff on infection control practices and ensuring that gloves are worn while administering injectable medications. The DHS and/or designee will complete audits of five residents receiving injectable medication for compliance 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 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) The systemic changes or this</p>	

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

PRINTED: 03/05/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155782	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/12/2024
NAME OF PROVIDER OR SUPPLIER  WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 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	
			deficiency will be completed by March 1, 2024		