

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

PRINTED: 04/16/2024

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 -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 03/25/2024
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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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(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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 03/25/24</p> <p>Facility Number: 012355 Provider Number: 155782 AIM Number: 201014410</p> <p>At this Emergency Preparedness survey, White Oak Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.90(a)</p> <p>The facility has 61 certified beds. At the time of the survey, the census was 54.</p> <p>Quality Review completed on 03/28/24</p>	E 0000		
K 0000 Bldg. 01	<p>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).</p> <p>Survey date: 03/25/24</p> <p>Facility Number: 012355 Provider Number: 155782 AIM Number: 201014410</p> <p>At this Life Safety Code survey, White Oak Health Campus was found not in compliance with</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Anderson	Executive Director	04/11/2024

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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K 0363 SS=E Bldg. 01	<p>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, fully sprinklered facility was determined to be Type V (111) construction. The facility has a fire alarm system with hard wired smoke detection in the corridors, areas open to the corridors, and resident rooms. The SNF certified health care occupancy was located on north end of the main building with the capacity for 61 residents and a census of 54 at the time of this survey.</p> <p>All areas accessible to residents and areas providing facility services are sprinklered.</p> <p>Quality Review completed on 03/28/24</p> <p>NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p>			

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	<p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 50 sets of resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect as many as 12 residents, 4 staff and 2 visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation made on 03/25/24 at 12:07 p.m. during a tour of the facility with the Director of Plant Operations (DPO) and the Administrator-in-Training, (AIT) the corridor door to resident room #204 did close completely but would not latch into the door frame. This</p>	K 0363	<p>/b></p> <p>1 Resident room 204's door was adjusted immediately by the DPO to allow for it to completely shut and latch into the door frame.</p> <p>2 All residents have the potential to be affected. Doors to all rooms will be audited for compliance and adjusted if found to be out of compliance.</p> <p>3 As a measure of ongoing compliance, the Director of Plant Operations and/or designee will conduct an audit of ten resident room doors monthly for 6 months.</p>	04/04/2024

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K 0753 SS=E Bldg. 01	<p>deficiency was acknowledged by the DPO at the time of observation who stated that he would adjust the door as soon as he could.</p> <p>This finding was reviewed with the DPO and the AIT at the exit conference on 03/25/24 at 2:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met:</p> <ul style="list-style-type: none"> o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. <p>19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect as many as 6 staff.</p>	K 0753	<p>Director of Plant Operations was educated on ensuring all resident room doors close completely and latch into the door frame.</p> <p>4 As a quality measure, the corrective action plan and audits will be monitored through our monthly QAPI meeting for 6 months to ensure 100% compliance.</p> <p>5 The systemic changes will be completed by April 4, 2024.</p> <p>/b></p> <p>1 The 2 containers of chafer fuel found were immediately removed from the shelf in the kitchen and disposed of properly by the Director of Plant</p>	04/04/2024	

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	<p>Findings include:</p> <p>Based on observation made on 03/25/24 at 12:07 p.m. during a tour of the facility with the Director of Plant Operations (DPO) and the Administrator-in-Training, (AIT) there were two open containers of 6-Hour chafer fuel sitting on a small shelf in the kitchen. Both of the chafer fuel containers had the containers tops off, the wicks exposed, and had been lit prior to being stored there. Based on interview at the time of observation, the DPO acknowledged the chafer fuel containers and stated that staff training would be done to prevent this from happening again. He then moved both containers to another location that was suitable for the storage of combustible items.</p> <p>This finding was reviewed with the DPO and the AIT at the exit conference on 03/25/24 at 2:00 p.m.</p> <p>3.1-19(b)</p>		<p>Operations.</p> <p>2 All residents have the potential to be affected. Inspection of all other chafer fuel canisters was completed to ensure that they were stored appropriately.</p> <p>3 As a measure of ongoing compliance, the Director of Food Services and all food service staff will be educated on proper storage of chafer fuel containers. The Director of Food Services and/or designee will ensure proper storage of these containers after portable food service equipment is used. The Director of Food Services and/or designee will conduct audits of the kitchen for compliance three times a week for four weeks, once a week for four weeks then monthly for four months.</p> <p>4 As a quality measure the Director of Food Services and/or designee will review and report any findings and associated corrective action until the campus is 100% compliant in our monthly QAPI meetings.</p> <p>5 The systemic changes will be completed by April 4, 2024.</p>	
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