

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 21, 22, 23, 24, 27, and 28, 2013</p> <p>Facility number: 012355 Provider number: 155782 AIM number: 201014410</p> <p>Survey team: Caitlyn Doyle, RN-TC Jennifer Redlin, RN Heather Hite, RN Janelyn Kulik, RN (January 21)</p> <p>Census bed type: SNF: 37 SNF/NF: 14 Residential: 36 Total: 87</p> <p>Census payor type: Medicare: 15 Medicaid: 11 Other: 61 Total: 87</p> <p>Residential Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>Submission of this plan of correction and credible allegation does not constitute an admission by the provider that the allegations are a true and accurate portrayal of the provisions of care in this facility. White Oak Health Campus submits this plan of correction as its letter of credible allegation and requests a desk review with paper compliance be considered in establishing the provider is in substantial compliance. We appreciate your consideration of this request.</p>	
---------	---	---------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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: 155782	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000223 SS=E	<p>Quality review completed on February 1, 2014, by Janelyn Kulik, RN.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from abuse related to a substantiated allegation of verbal abuse for 1 of 3 abuse allegations reviewed and 1 of 3 residents reviewed for abuse. (Resident #24)</p> <p>Findings include:</p> <p>The closed record for Resident #24 was reviewed on 1/24/13 at 9:17 a.m. The resident's diagnoses included, but were not limited to, hypertension, anemia, end stage renal disease, and depression.</p>	F000223	<p>1. Resident #24 no longer resides at the facility. PTA #1 was terminated. 2. Residents residing at the facility have the potential to be at risk for the alleged deficiency. Interviews will be conducted with current residents by Executive Director (ED) or designee to ensure they feel safe and free of abuse. Any concerns will be communicated to staff and addressed. Any concerns identified as reportable per guidelines will be reported to the Indiana State Department of Health. 3. ED or designee will in-service staff on the Abuse Policy. Concern logs will be reviewed for appropriate responses. Department Managers will be in-serviced on suspension</p>	02/27/2014

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 01/28/2014
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 6/21/13, indicated the resident was cognitively intact.</p> <p>Review of the resident concern form, dated 6/28/13 at 3:30 p.m., indicated Resident #24's niece reported to Director of Therapy that Physical Therapy Assistant (PTA) #1 was bullying Resident #24 and other residents.</p> <p>The immediate action taken included PTA #1 was suspended pending results of the investigation.</p> <p>Upon further investigation by the facility it was found the Director of Therapy had been approached by Physical Therapist (PT) #2 on 6/6/13 and indicated that he felt like PTA #1 was too aggressive with some of her patients and was inappropriately yelling at them. The Director of Therapy was approached by PTA #2 and Certified Occupational Therapy Assistant (COTA) #1 who reported PTA #1 was too pushy with a resident and had gotten into a verbal argument with that resident during therapy. The Director of Therapy spoke to PTA #1 about incident at this time but did not report the</p>		<p>of staff pending investigation, timely reporting and initiating the investigation process. Five resident interviews will be conducted by ED or designee weekly x 1 month, bi-monthly x 2 months and randomly x 4 months. 4. Interview results will be brought to monthly Quality Assurance (QA) meetings. QA Committee will review trends x 6 months or until 100% compliance is achieved.</p>		

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>allegation to the Administrator.</p> <p>The Director of Therapy had been approached by RN #1 on 6/27/13 and indicated she had overheard PTA #1 yelling at a resident in her room because the resident was trying to refuse therapy. The allegation was not reported to the Administrator at this time.</p> <p>On 6/28/13 at 7:45 a.m., Director of Therapy completed coaching and counseling with PTA #1.</p> <p>On 6/28/13 at 9:00 a.m., the Director of Therapy was approached by a resident who requested that she be seen by a different therapist. The resident indicated she had never worked with PTA #1 before but had seen how PTA #1 treated her patients and did not want her as her therapist. The allegation was not reported to the Administrator at this time.</p> <p>On 6/28/13 at 11:00 a.m., the Director of Therapy was approached by PTA #2 who reported a resident had reported to her, PTA #1 had come into her room and "bawled" her out for not being up and dressed and ready for therapy. The allegation was not reported to the</p>			

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>Administrator at this time.</p> <p>On 6/28/13 at 12:00 p.m., the Director of Therapy was approached by PTA #2 and COTA #1 who reported that PTA #1 was yelling at a resident in the therapy gym because the resident was not motivated to perform activities.</p> <p>Review of the five day follow up indicated interviews were conducted with co-workers of PTA #1 and the resident's physician was notified. Interviews were conducted by the Social Service Director with residents who received therapy and were alert and oriented. Based on the findings of the facility's investigation, PTA #1 was "terminated from (facility name) effective 7/1/13 for not following customer service standards when communicating with residents during therapy sessions. One resident felt that it was bullying and co-workers described her as yelling inappropriately and being too pushy with residents."</p> <p>Interview with the Administrator on 1/23/13 at 11:35 a.m., indicated she was not personally notified of the allegations of verbal abuse until 6/28/13. She further indicated PTA</p>			
--	---	--	--	--

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 01/28/2014
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>#1 was suspended immediately after the allegations were reported to her. She indicated after investigation, PTA #1 was terminated due to the allegations being substantiated and did not return to the facility. She further indicated she completed an inservice on abuse and reporting abuse with the therapy staff. She indicated she should have been notified immediately at the time of the very first allegation of verbal abuse involving PTA #1 on 6/6/13.</p> <p>3.1-27(b)</p>				

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 01/28/2014	
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225	1. Resident #24 no longer resides	02/27/2014			

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 01/28/2014
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>interview, the facility failed to report allegations of abuse timely to the Administrator of the facility and failed to notify the Indiana State Department of Health (ISDH) of an allegation of abuse, for 2 of 3 abuse allegations reviewed. (Resident #24 and Resident #54)</p> <p>Findings include:</p> <p>1. The closed record for Resident #24 was reviewed on 1/24/13 at 9:17 a.m. The resident's diagnoses included, but were not limited to, hypertension, anemia, end stage renal disease, and depression.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 6/21/13, indicated the resident was cognitively intact.</p> <p>Review of the resident concern form, dated 6/28/13 at 3:30 p.m., indicated Resident #24's niece reported to Director of Therapy that Physical Therapy Assistant (PTA) #1 was bullying Resident #24 and other residents.</p> <p>The immediate action taken included PTA #1 was suspended pending results of the investigation.</p>		<p>at the facility. PTA #1 was terminated.2. Residents residing at the facility have the potential to be at risk of the alleged deficiency. Interviews will be conducted with current residents by Executive Director (ED) or designee to ensure they feel safe and free of abuse. Any concerns will be communicated to staff and addressed. Any concerns identified as reportables per guidelines will be reported to the Indiana State Department of Health.3. ED or designee will in-service staff on Abuse Policy including timely reporting. Concern logs will be reviewed for appropriate responses. Department Managers will be in-serviced on suspension of staff pending investigation, timely reporting and initiating the investigation process. Five resident interviews will be conducted by ED or designee weekly x 1 month, bi-monthly x 2 months and randomly x 4 months.4. Interview results will be brought to monthly Quarterly Assurance (QA) meetings. QA Committee will review trends x 6 months or until 100% compliance is achieved.</p>		

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>Upon further investigation by the facility it was found the Director of Therapy had been approached by Physical Therapist (PT) #2 on 6/6/13 and indicated that he felt like PTA #1 was too aggressive with some of her patients and was inappropriately yelling at them. The Director of Therapy was approached by PTA #2 and Certified Occupational Therapy Assistant (COTA) #1 who reported PTA #1 was too pushy with a resident and had gotten into a verbal argument with that resident during therapy. The Director of Therapy spoke to PTA #1 about incident at this time but did not report the allegation to the Administrator.</p> <p>The Director of Therapy had been approached by RN #1 on 6/27/13 and indicated she had overheard PTA #1 yelling at a in her room because the resident was trying to refuse therapy. The allegation was not reported to the Administrator at this time.</p> <p>On 6/28/13 at 7:45 a.m., Director of Therapy completed coaching and counseling with PTA #1.</p> <p>On 6/28/13 at 9:00 a.m., the Director of Therapy was approached by a resident who requested that she be</p>			
--	---	--	--	--

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>seen by a different therapist. The resident indicated she had never worked with PTA #1 before but had seen how PTA #1 treated her patients and did not want her as her therapist. The allegation was not reported to the Administrator at this time.</p> <p>On 6/28/13 at 11:00 a.m., the Director of Therapy was approached by PTA #2 who reported a resident had reported to her, PTA #1 had come into her room and "bawled" her out for not being up and dressed and ready for therapy. The allegation was not reported to the Administrator at this time.</p> <p>On 6/28/13 at 12:00 p.m., the Director of Therapy was approached by PTA #2 and COTA #1 who reported that PTA #1 was yelling at a resident in the therapy gym because the resident was not motivated to perform activities.</p> <p>Review of the five day follow up indicated interviews were conducted with co-workers of PTA #1 and the resident's physician was notified. Interviews were conducted by the Social Service Director with residents who received therapy and were alert and oriented. Based on</p>			

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>the findings of the facility's investigation, PTA #1 was "terminated from (facility name) effective 7/1/13 for not following customer service standards when communicating with residents during therapy sessions. One resident felt that it was bullying and co-workers described her as yelling inappropriately and being too pushy with residents."</p> <p>Interview with the Administrator on 1/23/13 at 11:35 a.m., indicated she was not personally notified of the allegations of verbal abuse until 6/28/13. She further indicated PTA #1 was suspended immediately after the allegations were reported to her. She indicated after investigation, PTA #1 was terminated due to the allegations being substantiated and did not return to the facility. She further indicated she completed an inservice on abuse and reporting abuse with the therapy staff. She indicated she should have been notified immediately at the time of the very first allegation of verbal abuse involving PTA #1 on 6/6/13.</p> <p>2. The record for Resident #54 was reviewed on 1/24/14 at 9:18 a.m. The resident's diagnoses included, but were not limited to,</p>			

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 01/28/2014
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>hypertension, anemia, osteoarthritis, and dementia.</p> <p>Review of Quarterly MDS Assessment dated 11/13/13, indicated the resident was cognitively impaired.</p> <p>Review of an incident investigation dated 7/23/13 at 2:00 a.m., indicated two CNAs entered Resident #54's room, turned on the light, and were going to perform a bed check on Resident #54. Resident #54 started yelling at the CNAs before they came close to her and told them they had no right to be in her room and to touch her would be rape. The CNAs left the room and got the nurse.</p> <p>Upon further investigation by the facility it was found that the CNAs had reported the incident to the nurse and the nurse had reported the incident to the Director of Health Services (DHS). The DHS did not report the allegation to the Administrator or to ISDH.</p> <p>Interview with the Administrator on 1/23/13 at 11:35 a.m., indicated she was off work for a couple of days and upon her return to work on 7/26/13 she was notified about the</p>				

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>incident by a phone call she received from the Ombudsman. The Ombudsman indicated she received a complaint that Resident #54 had used the word rape. Administrator indicated she immediately started an investigation and reported the incident to ISDH at that time. She further indicated that when she was off work, the DHS was responsible for handling and reporting incidents to ISDH. She indicated the DHS at that time was new to the position and thought that because two CNAs were present at the time of Resident #54's allegations, it was not considered abuse. Administrator indicated DHS was re-educated about documentation and reporting incidents and was no longer employed by the facility. She further indicated DHS should have notified her of the allegation and reported the allegation to ISDH on 7/23/13.</p> <p>3.1-28(c) 3.1-28(e)</p>			

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 01/28/2014
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F000226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow the facility's abuse policy, related to reporting allegations of abuse to the Administrator immediately, and reporting an allegation to the Indiana State Department of Health (ISDH) for 2 of 3 abuse allegations reviewed. (Resident #24 and Resident #54)</p> <p>Findings include:</p> <p>1. The closed record for Resident #24 was reviewed on 1/24/13 at 9:17 a.m. The resident's diagnoses included, but were not limited to, hypertension, anemia, end stage renal disease, and depression.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 6/21/13, indicated the resident was cognitively intact.</p> <p>Review of the resident concern form, dated 6/28/13 at 3:30 p.m., indicated Resident #24's niece reported to</p>	F000226	<p>1. Resident #24 no longer resides at the facility. PTA #1 was terminated.2. Residents residing at the facility have the potential to be at risk of the alleged deficiency. Interviews will be conducted with current residents by Executive Director (ED) or designee to ensure they feel safe and free of abuse. Any concerns will be communicated to staff and addressed. Any concerns identified as reportables per guidelines will be reported to the Indiana State Department of Health.3. ED or designee will in-service staff on Abuse policy including timely reporting. Concern logs will be reviewed for appropriate response. Department Managers will be in-serviced on suspension of staff pending investigation, timely reorting and initiating the investigation process. Five resident interviews will be conducted by ED or designee weekly x 1 month, bi-monthly x2 months and randomly x 4 months.4. Interview results will be brought to monthly Quarterly Assurance (QA) meetings. QA Committee will review trends x 6 months or until 100% compliance</p>	02/27/2014	

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Director of Therapy that Physical Therapy Assistant (PTA) #1 was bullying Resident #24 and other residents.</p> <p>The immediate action taken included PTA #1 was suspended pending results of the investigation.</p> <p>Upon further investigation by the facility it was found the Director of Therapy had been approached by Physical Therapist (PT) #2 on 6/6/13 and indicated that he felt like PTA #1 was too aggressive with some of her patients and was inappropriately yelling at them. The Director of Therapy was approached by PTA #2 and Certified Occupational Therapy Assistant (COTA) #1 who reported PTA #1 was too pushy with a resident and had gotten into a verbal argument with that resident during therapy. The Director of Therapy spoke to PTA #1 about incident at this time but did not report the allegation to the Administrator.</p> <p>The Director of Therapy had been approached by RN #1 on 6/27/13 and indicated she had overheard PTA #1 yelling at a in her room because the resident was trying to refuse therapy. The allegation was not reported to the Administrator at</p>		is achieved.	

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>this time.</p> <p>On 6/28/13 at 7:45 a.m., Director of Therapy completed coaching and counseling with PTA #1.</p> <p>On 6/28/13 at 9:00 a.m., the Director of Therapy was approached by a resident who requested that she be seen by a different therapist. The resident indicated she had never worked with PTA #1 before but had seen how PTA #1 treated her patients and did not want her as her therapist. The allegation was not reported to the Administrator at this time.</p> <p>On 6/28/13 at 11:00 a.m., the Director of Therapy was approached by PTA #2 who reported a resident had reported to her, PTA #1 had come into her room and "bawled" her out for not being up and dressed and ready for therapy. The allegation was not reported to the Administrator at this time.</p> <p>On 6/28/13 at 12:00 p.m., the Director of Therapy was approached by PTA #2 and COTA #1 who reported that PTA #1 was yelling at a resident in the therapy gym because the resident was not motivated to perform activities.</p>			

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 01/28/2014	
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Review of the five day follow up indicated interviews were conducted with co-workers of PTA #1 and the resident's physician was notified. Interviews were conducted by the Social Service Director with residents who received therapy and were alert and oriented. Based on the findings of the facility's investigation, PTA #1 was "terminated from (facility name) effective 7/1/13 for not following customer service standards when communicating with residents during therapy sessions. One resident felt that it was bullying and co-workers described her as yelling inappropriately and being too pushy with residents."</p> <p>Interview with the Administrator on 1/23/13 at 11:35 a.m., indicated she was not personally notified of the allegations of verbal abuse until 6/28/13. She further indicated PTA #1 was suspended immediately after the allegations were reported to her. She indicated after investigation, PTA #1 was terminated due to the allegations being substantiated and did not return to the facility. She further indicated she completed an inservice on abuse and reporting abuse with the therapy staff. She</p>						

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 01/28/2014
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>indicated she should have been notified immediately at the time of the very first allegation of verbal abuse involving PTA #1 on 6/6/13.</p> <p>2. The record for Resident #54 was reviewed on 1/24/14 at 9:18 a.m. The resident's diagnoses included, but were not limited to, hypertension, anemia, osteoarthritis, and dementia.</p> <p>Review of Quarterly MDS Assessment dated 11/13/13, indicated the resident was cognitively impaired.</p> <p>Review of an incident investigation dated 7/23/13 at 2:00 a.m., indicated two CNAs entered Resident #54's room, turned on the light, and were going to perform a bed check on Resident #54. Resident #54 started yelling at the CNAs before they came close to her and told them they had no right to be in her room and to touch her would be rape. The CNAs left the room and got the nurse.</p> <p>Upon further investigation by the facility it was found that the CNAs had reported the incident to the nurse and the nurse had reported the incident to the Director of Health</p>				

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Services (DHS). The DHS did not report the allegation to the Administrator or to ISDH.</p> <p>Interview with the Administrator on 1/23/13 at 11:35 a.m., indicated she was off work for a couple of days and upon her return to work on 7/26/13 she was notified about the incident by a phone call she received from the Ombudsman. The Ombudsman indicated she received a complaint that Resident #54 had used the word rape. Administrator indicated she immediately started an investigation and reported the incident to ISDH at that time. She further indicated that when she was off work, the DHS was responsible for handling and reporting incidents to ISDH. She indicated the DHS at that time was new to the position and thought that because two CNAs were present at the time of Resident #54's allegations, it was not considered abuse. Administrator indicated DHS was re-educated about documentation and reporting incidents and was no longer employed by the facility. She further indicated DHS should have notified her of the allegation and reported the allegation to ISDH on 7/23/13.</p> <p>A facility policy on Abuse dated</p>			

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 01/28/2014	
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000282 SS=D	<p>9/16/11, and received as current from the Administrator, indicated "...c. ii. 5. Staff is required to report concerns, incidents and grievances immediately to your manager and/or Executive Director and Director of Health Services...d. iv. Immediately notify the Executive Director. If the Executive Director is absent they may appoint a designee...d. vii. The Executive Director is responsible for:</p> <p>1. Notification of the State Department of Health (per State guidelines)..."</p> <p>3.1-28(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow physician's orders and care plans, related to monitoring of pulse prior to the administration of blood pressure (BP) medications and incorrect sliding scale insulin administration for 1 of 5 residents reviewed for unnecessary medications of the 5 who met the criteria. (Resident #28)</p>	F000282	<p>1. Resident #28 had no adverse affects. Physician was notified.2. Residents with physician's orders to monitor pulse prior to administration of blood pressure medications and sliding scale insulin administration have the potential to be at risk for alleged deficient practice. Medication Administration Records (MARs) of residents identified to have potential to be at risk have been audited. Physicians will be notified of residents that are</p>	02/27/2014			

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 01/28/2014
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Findings include:</p> <p>The record for Resident #28 was reviewed on 1/23/14 at 9:46 a.m. The resident's diagnoses included, but were not limited to, type II diabetes mellitus, hypertension, atrial fibrillation, and anemia.</p> <p>Review of the Physician's Recapitulation Orders, dated 12/2013, indicated an order for sliding scale (insulin given per blood glucose test result) Novolin R (insulin) subcutaneous (under the skin) level 3 moderate scale AC (before meals) and HS (at bedtime), with the following doses: < (less than)70=Hold insulin 70-150=No coverage 151-200= 3 units 201-250= 6 units 251-300= 9 units 301-350= 11 units 351-400= 13 units > (greater than) 400=Call Physician</p> <p>The Medication Administration Record (MAR) dated 12/2013, indicated the resident's blood glucose test result on 12/2/13 at bedtime was 194 and no insulin was given. The resident should have received 3 units of insulin. The resident's blood glucose test result</p>		<p>noted to be out of compliance with physician's orders .3. Licensed staff will be in-serviced by Director of Health Services (DHS) or designee on following physician's orders related to monitoring of pulse prior to administration of blood pressure medications and sliding scale insulin administration. DHS or designee will audit MARs 5 x's per week x 1 month, 3 x's per week x 1 month, weekly x 4 months.4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.</p>		

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>on 12/5/13 at bedtime was 155 and no insulin was given. The resident should have received 3 units of insulin. The resident's blood glucose test result on 12/6/13 before dinner was 218 and no insulin was given. The resident should have received 6 units of insulin. The resident's blood glucose test result on 12/13/13 at bedtime was 209 and no insulin was given. The resident should have received 6 units of insulin. The resident's blood glucose test result on 12/14/13 at bedtime was 220 and no insulin was given. The resident should have received 6 units of insulin.</p> <p>Continued review of the Physician's Recapitulation Orders, dated 12/2013, indicated an order for Sotalol (a blood pressure medication) 80 mg (milligrams) 1 tablet by mouth every day for hypertension, hold for HR (heart rate) less than 50.</p> <p>The MAR dated 12/2013, indicated there was no pulse obtained prior to the administration of the Sotalol on December 3, 4, 7, 8, 9, 13, 14, 15, 16, 20, 21, 25, 28, 2013.</p> <p>The MAR dated 1/2014, indicated there was no pulse obtained prior to</p>			

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>the administration of the Sotalol on 1/1/14.</p> <p>There was lack of documentation on the Daily Skilled Nurses' Notes and Skilled Nursing Assessments to indicate the pulse had been obtained prior to the administration of the Sotalol on the above dates.</p> <p>Review of current care plans indicated potential for altered cardiac output. The Nursing interventions included administer cardiac medications per physician's orders.</p> <p>Interview with the Director of Health Services (DHS) on 1/24/14 at 2:36 p.m., indicated insulin should have been given according to the sliding scale and the insulin dose should have been documented on the MAR. She indicated the pulse should have been obtained prior to administration of the medication and documented on the MAR.</p> <p>3.1-35(g)(2)</p>			

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 01/28/2014	
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications related to monitoring of pulse prior to the administration of blood pressure (BP) medications and incorrect sliding scale insulin administration for 1 of 5 residents reviewed for unnecessary medications of the 5 who met the criteria. (Resident #28)</p> <p>Findings include:</p>	F000329	<p>1. Resident # 28 had no adverse affects. Physician was notified. 2. Residents with physician's orders to monitor pulse prior to administration of blood pressure medications and sliding scale insulin administration have the potential to be at risk for alleged deficient practice. Medication Administration Records (MARs) of residents identified to have potential to be at risk have been audited. Physicians will be notified of residents that are noted to be out of compliance with physician's orders.3.</p>	02/27/2014			

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 01/28/2014	
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>The record for Resident #28 was reviewed on 1/23/14 at 9:46 a.m. The resident's diagnoses included, but were not limited to, type II diabetes mellitus, hypertension, atrial fibrillation, and anemia.</p> <p>Review of the Physician's Recapitulation Orders, dated 12/2013, indicated an order for sliding scale (insulin given per blood glucose test result) Novolin R (insulin) subcutaneous (under the skin) level 3 moderate scale AC (before meals) and HS (at bedtime), with the following doses: < (less than)70=Hold insulin 70-150=No coverage 151-200= 3 units 201-250= 6 units 251-300= 9 units 301-350= 11 units 351-400= 13 units > (greater than) 400=Call Physician</p> <p>The Medication Administration Record (MAR) dated 12/2013, indicated the resident's blood glucose test result on 12/2/13 at bedtime was 194 and no insulin was given. The resident should have received 3 units of insulin. The resident's blood glucose test result on 12/5/13 at bedtime was 155 and</p>				<p>Licensed staff will be in-serviced by Director of Health Services (DHS) or designee on following physician's orders related to monitoring of pulse prior to administration of blood pressure medications and sliding scale insulin administration. DHS or designee will audit MARs 5 x's per week x 1 month, 3 x's per week x 1 month and weekly x 4 months.4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.</p>		

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>no insulin was given. The resident should have received 3 units of insulin. The resident's blood glucose test result on 12/6/13 before dinner was 218 and no insulin was given. The resident should have received 6 units of insulin. The resident's blood glucose test result on 12/13/13 at bedtime was 209 and no insulin was given. The resident should have received 6 units of insulin. The resident's blood glucose test result on 12/14/13 at bedtime was 220 and no insulin was given. The resident should have received 6 units of insulin.</p> <p>Continued review of the Physician's Recapitulation Orders, dated 12/2013, indicated an order for Sotalol (a blood pressure medication) 80 mg (milligrams) 1 tablet by mouth every day for hypertension, hold for HR (heart rate) less than 50.</p> <p>The MAR dated 12/2013, indicated there was no pulse obtained prior to the administration of the Sotalol on December 3, 4, 7, 8, 9, 13, 14, 15, 16, 20, 21, 25, 28, 2013.</p> <p>The MAR dated 1/2014, indicated there was no pulse obtained prior to the administration of the Sotalol on</p>			

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 01/28/2014	
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>1/1/14.</p> <p>There was lack of documentation on the Daily Skilled Nurses' Notes and Skilled Nursing Assessments to indicate the pulse had been obtained prior to the administration of the Sotalol on the above dates.</p> <p>Interview with the Director of Health Services (DHS) on 1/24/14 at 2:36 p.m., indicated insulin should have been given according to the sliding scale and the insulin dose should have been documented on the MAR. She indicated the pulse should have been obtained prior to administration of the medication and documented on the MAR.</p> <p>3.1-48(a)(6)</p>						

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 01/28/2014	
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper medication labeling for 2 of 25 medications given to 1 of</p>	F000431	1. Resident #111 received medication as ordered by the physician during the time of the survey. Label was placed on medication card during the time	02/27/2014			

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 01/28/2014
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>10 residents observed during the Medication Administration Observation. (Resident #111)</p> <p>Findings include:</p> <p>During the Medication Administration Observation on 1/23/14 at 4:11 p.m., the medication card labels for Resident #111 indicated the following orders:</p> <p>1) Norco 5/325 give two - 1/2 tablets PO BID (7A & 7P). LPN #1 gave one - 1/2 tab during the observation.</p> <p>2) Carbidopa/Levo 25/100 (Sinemet) Give two - 1/2 tabs PO daily at 9am. LPN #1 gave one - 1/2 tab during the observation.</p> <p>Physician's Orders and the MAR (Medication Administration Record) both dated January 2014 indicated the following current orders for Resident #111:</p> <p>1) Norco 5/325 - Give 1 tab @ 7A & 7P & 1/2 tab @ 3P. 2) Carbidopa/Levo 25/100 (Sinemet) - Give one - 1/2 tab @ 11A & 3P.</p> <p>In an interview with LPN #1 on 1/23/14 at 4:20 p.m., she indicated if the order had been changed from what the original resident medication card reads, sometimes the card</p>		<p>of survey.2. Residents receiving medications have potential to be at risk of alleged deficient practice. Audits were completed to match physician's orders to medication cards for accuracy on residents identified to have potential to be at risk. Labels will be placed on medication cards as needed.3. Licensed staff will be in-serviced by Director of Health Services (DHS) on Medication Ordering and Receiving from Pharmacy policy for Medication Labels. New orders with directions related to medications will be audited against the medication cards by DHS or designee 5 x's per week x 1 month, 3 x's per week x 1 month and weekly x 4 months.4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.</p>		

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>would have "order change" on it. Staff should always go by what was on the MAR for giving medications. She further indicated neither medication card for Resident #111 was labeled correctly according to the MAR or was marked with "order change."</p> <p>During an interview with the ADHS (Assistant Director of Health Services) Consultant & the DHS (Director of Health Services) on 1/23/14 at 5:00 p.m., both indicated when an order was changed, the nurse signing off on the order change was supposed to put a sticker reflecting "order change" on the resident's medication card. The nurse administering medications to residents should go by what was on the MAR for proper dosing instructions. The pharmacy consultant should also be monitoring monthly the correct labeling of the medication cards.</p> <p>A Medication Ordering and Receiving from Pharmacy policy for Medication Labels was provided by the ADHS Consultant on 1/28/14 at 10:45 a.m. and indicated as current. The policy indicated "Medication labels are not altered, modified or marked in any way by nursing</p>			

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 01/28/2014
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>personnel. Contents are not transferred from one container to another. Under no circumstances are unattached labels requested or accepted from the pharmacy. Only the pharmacy may place a label on the medication container.</p> <p>1) If the physician's directions for use change or the label is inaccurate, the nurse may place a "change of order - check chart" label on the container indicating there is a change in direction for use, taking care not to cover important label information.</p> <p>2) When such a label appears on the container, the medication nurse checks the resident's medication administration record (MAR) or the physicians order for current information.</p> <p>3) The dispensing pharmacy is informed prior to the next refill of the prescription so the new container will show an accurate label."</p> <p>3.1-25(j) 3.1-25(k)(5)</p>				

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 01/28/2014	
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
R000000	The following State Residential findings cited are in accordance with 410 IAC 16.2.	R000000	Submission of this plan of correction and credible allegation does not constitute an admission by the provider that the allegations are a true and accurate portrayal of the provisions of care in this facility. White Oak Health Campus submits this plan of correction as its letter of credible allegation and requests a desk review with paper compliance be considered in establishing the provider is in substantial compliance. We appreciate your consideration of this request.				
R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure physician's orders were followed, related to laboratory (lab) tests not completed as ordered for 2 of 5 residents reviewed for physicians' orders in a total sample of 5. (Resident #112 and #145) Findings include: 1. The record for Resident #112 was	R000241	1. Residents #112 and #145 had no adverse affects noted. Physicians were notified of missed laboratory (lab) tests.2. Residents with physician's orders related to lab tests have the potential to be at risk of alleged deficient practice. Audits will be completed on residents with physician's orders for lab tests to ensure physician's orders were followed. Physicians will be notified of any missed labs.3. Licensed staff will be in-serviced	02/27/2014			

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>reviewed on 1/28/14 at 11:30 a.m. The resident's diagnoses included, but were not limited to, iron deficiency anemia, hypertension, and chronic kidney disease.</p> <p>The Physician's Recapitulation Orders, dated 1/2014, indicated the following laboratory orders: -Iron profile every six months in February and August. -Fasting Vitamin D 25 hydroxy every six months in February and August. -Fasting TSH (thyroid stimulating hormone, a test for thyroid function) every six months in February and August. -Fasting B12 level (a test for Vitamin B12) every six months in February and August. -Fasting lipids every six months in February and August. -Fasting BMP (Basic Metabolic Panel, electrolyte test), HGBA1C (hemoglobin A1C, blood glucose test), ALT(a liver function test), CBC (complete blood count), and lipid panel every six months in February and August.</p> <p>Review of lab results indicated the lipid panel, TSH, iron profile, Vitamin D 25 hydroxy, HGBA1C, and Vitamin B12 level had been completed on 2/28/13. There was</p>		<p>by Director of Health Services (DHS) or designee on facility system for tracking labs and following physician's orders related to labs. DHS or designee will audit labs as ordered by physician for compliance. Audits will be done 5 x's per week x 1 month, 3 x's per week x 1 month and weekly x 4 months.4. Audit results will be brought to monthly Quality Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.</p>	

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>lack of documentation in the record to indicate the BMP, ALT, and CBC had been completed for February 2013.</p> <p>There was lack of documentation in the record to indicate the iron profile, Vitamin D 25 hydroxy, TSH, B12 level, BMP, HGBA1C, ALT, CBC, and lipid panel had been completed for August 2013</p> <p>During an interview on 1/28/14 at 11:55 a.m., LPN #2 indicated she was unsure why the lab tests were not completed as ordered.</p> <p>During an interview on 1/28/14 at 12:27 p.m., the Assistant Director of Health Services (ADHS) indicated the labs were missed and should have been obtained as ordered.</p> <p>2. The record for Resident #145 was reviewed on 1/28/14 at 10:50 a.m. Diagnoses included but were not limited to: hypothyroidism, hyperlipidemia and dementia.</p> <p>A review of the Physician's Orders for January 2014 indicated the following orders for laboratory blood testing: Fasting lipids, CMP (comprehensive metabolic panel - indicates current</p>			

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>functional status of several organs) , CBC (complete blood count) q (every) 6 mo. (months) - (Feb/ Aug) TSH (thyroid stimulating hormone, a test for thyroid function) q 6 mo. (June/ Dec)</p> <p>Results for laboratory testing indicate the most recent CBC & CMP were completed 8/1/13 as ordered. The most recent result for the lipid panel was dated 2/27/13 and the most recent result for TSH was dated 6/3/13. There was no result for an August 2013 lipid panel test or a December 2013 TSH test.</p> <p>In an interview with the DHS (Director of Health Services) and ADHS (Assistant DHS) on 1/28/14 at 3:30 p.m., both indicated there were not any more recent results for the lipid panel or TSH and the lab had no record of them having been done. They further indicated they had found a problem with the ordering system for labs in December for the Assisted Living and had taken measures to fix those issues, but the above lab orders for Resident #145 were missed.</p>			

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 01/28/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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