

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 03/08/2016
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NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 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 29, March 1, 2, 3, 4, 7 and 8, 2016.</p> <p>Facility number: 012355 Provider number: 155782 AIM number: 201014410</p> <p>Census bed type: SNF: 40 SNF/NF: 19 Residential: 35 Total: 94</p> <p>Census payor type: Medicare: 19 Medicaid: 15 Other: 25 Total: 59</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on February 29-March 8, 2016. Please accept this Plan of Correction as White Oak Health Campus' credible allegation of compliance effective April 7, 2016. White Oak Health Campus respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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.

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F 0329 SS=D Bldg. 00	<p>483.25(l) 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 Pharmacy recommendations were implemented related to a gradual dose reduction for a resident receiving a mood stabilizer for 1 of 5 residents reviewed for unnecessary medications. (Resident # 28)</p> <p>Finding includes: The record for Resident #28 was</p>	F 0329	<p>1) Resident #28 had GDR initiated by physician for Depakote on 3/16/2016. This will be monitored x 14 days.2) All residents have the potential to be affected by this practice. Any resident receiving psychotropic medication will have chart reviewed to ensure pharmacy recommendations received a response from physician.3) Pharmacy Consultant, Director of Health Services and Social</p>	04/07/2016

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	<p>reviewed on 03/03/2016 at 9:10 a.m. The resident's diagnoses included, but were not limited to, depression, anxiety and chronic kidney disease.</p> <p>Review of a Pharmacy recommendation dated 11/10/15 indicated, "recent mood and behavior assessments completed by the social worker did not reflect any behaviors and only depressive symptoms. In an effort to minimize the medication regimen, and to determine if medication had potentially contributed to having little energy and being tired, reduce Depakote (mood stabilizer) to 125 mg (milligrams) twice a day and 250 mg at bedtime."</p> <p>A "Note to Attending Physician/Prescriber," dated 11/10/15 lacked a response from the Physician regarding the GDR (Gradual Dose Reduction)."</p> <p>The Physician Order Summary for February 2016 indicated the resident was to have received Depakote 125 mg capsule, give 2 capsules orally three times daily.</p> <p>The February 2016 Medication Administration Sheet indicated the resident had received the Depakote 250 mg three times a day beginning on</p>		<p>Services Director will be re-educated on process related to pharmacy recommendations. Pharmacy consultant will make recommendations monthly. DON or designee will review residents on psychotropic medications and pharmacy recommendations monthly and follow up with attending physicians on recommendations for gradual dose reduction as needed. Recommendations without nursing/physician follow-up will be reported to DON or designee from previous month & will be reported as a new recommendation during the current month's visit. 4) QAA will monitor findings for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly x 6 months or until 100% compliance is achieved.</p>	

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F 0428 SS=D Bldg. 00	<p>2/19/15.</p> <p>Interview with the Director of Nursing on 3/3/16 at 2:43 p.m., indicated the gradual dose reduction of the resident's Depakote was missed. She further indicated the facility had changed pharmacies at that time and the Physician did not receive the recommendation as he should have.</p> <p>3.1-48(b)(2)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure Pharmacy recommendations were implemented related to a gradual dose reduction for a resident receiving a mood stabilizer for 1 of 5 residents reviewed for unnecessary medications. (Resident # 28)</p> <p>Finding includes:</p> <p>The record for Resident #28 was reviewed on 03/03/2016 at 9:10 a.m. The resident's diagnoses included, but were</p>	F 0428	<p>1) Resident #28 had GDR initiated by physician for Depakote on 3/16/2016. This will be monitored x 14 days.2) All residents have the potential to be affected by this practice. Any resident receiving psychotropic medication will have chart reviewed to ensure pharmacy recommendations received a response from physician.3) Pharmacy Consultant, Director of Nursing and Social Services Director will be re-educated on process related to pharmacy recommendations. Pharmacy</p>	04/07/2016

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	<p>not limited to, depression, anxiety and chronic kidney disease.</p> <p>Review of a Pharmacy recommendation dated 11/10/15 indicated, "recent mood and behavior assessments completed by the social worker did not reflect any behaviors and only depressive symptoms. In an effort to minimize the medication regimen, and to determine if medication had potentially contributed to having little energy and being tired, reduce Depakote (mood stabilizer) to 125 mg (milligrams) twice a day and 250 mg at bedtime."</p> <p>A "Note to Attending Physician/Prescriber," dated 11/10/15 lacked a response from the Physician regarding the GDR (Gradual Dose Reduction)."</p> <p>The Physician Order Summary for February 2016 indicated the resident was to have received Depakote 125 mg capsule, give 2 capsules orally three times daily.</p> <p>The February 2016 Medication Administration Sheet indicated the resident had received the Depakote 250 mg three times a day beginning on 2/19/15.</p>		<p>consultant will make recommendations monthly. Recommendations without nursing/physician follow-up will be reported to DON or designee from previous month & will be reported as a new recommendation during the current month's visit. 4) QAA will monitor findings for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly x 6 months or until 100% compliance is achieved.</p>	

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F 0465 SS=B Bldg. 00	<p>Interview with the Director of Nursing on 3/3/16 at 2:43 p.m., indicated the gradual dose reduction of the resident's Depakote was missed. She further indicated the facility had changed pharmacies at that time and the Physician did not receive the recommendation as he should have.</p> <p>3.1-25 (j)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain an environment that was safe, clean, and in a state of good repair, related to marred and gouged walls and doors, and discolored bathroom pull light cords for 2 of the 3 Halls throughout the facility. (200 Hall and 300 Hall)</p> <p>Findings include:</p> <p>During the Environmental tour on 3/8/16 at 10:20 a.m. - 10:40 a.m., with the Director of Plant Operations and the Director of Environmental services, the following was observed:</p> <p>1. 200 Hall</p>	F 0465	<p>1) Observations in Rm 203, 210, 214, 217 & 303 have been addressed & fixed as of 3/18/16. No adverse affects were noted. 2) Residents residing at the facility have the potential to be at risk of the alleged deficiency. Rounds will be conducted to inspect walls for marring & gouging, doors for gouges and cleanliness of pull light cords. Areas that are identified that do not provide a safe and functional environment will be repaired or replaced. 3) Director of Plant Operations (DPO) and Environmental staff will be re-educated by Executive Director (ED) or designee on providing a functional and safe environment. DPO or designee will audit walls for marring & gouges, doors for gouges and cleanliness of pull light cords</p>	04/07/2016

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	<p>a. In room 203, the bathroom wall was marred and the pull light cord had brown discolorations. Two residents resided in the room.</p> <p>b. In room 210, the bathroom wall was marred, the pull light cord had brown discolorations, and the wall behind and at the head of bed B was gouged. Two residents resided in the room.</p> <p>c. In room 214, the wall behind the recliner was gouged. Two residents resided in the room.</p> <p>d. In room 217, the bathroom wall was marred and gouged, and the bottom of the dressers for bed B were gouged. Two residents resided in the room.</p> <p>2. 300 Hall</p> <p>a. In room 303, the inside bottom of the bathroom door was gouged. One resident resided in the room.</p> <p>Interview with the Director of Plant Operations and the Director of Environmental Services at the time of the tour indicated all areas were in need of repair or to be replaced. The Director of Plant Operations indicated he had stressed with staff to send him work</p>		<p>weekly x 6 months. 4) QAA will monitor findings for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly x 6 months or until 100% compliance is achieved.</p>	

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R 0000 Bldg. 00	orders if things were in need of repair. 3.1-19(f) This visit was for a State Residential Licensure Survey. Residential Census: 35 Sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.	R 0000	The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on February 29-March 8, 2016. Please accept this Plan of Correction as White Oak Health Campus' credible allegation of compliance effective April 7, 2016. White Oak Health Campus respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall			

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	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to assessment of a dialysis access site for 1 of 1 residents reviewed for dialysis in a total sample of 8. (Resident #4)</p> <p>Finding includes:</p> <p>The record for Resident #4 was reviewed on 3/7/16 at 3:00 p.m. The resident's diagnoses included, but were not limited to, hypertension, congestive heart failure, and hyperlipidemia.</p> <p>Review of the 3/2016 Physician Order Summary (POS) indicated the resident received dialysis on Tuesdays, Thursdays, and Saturdays. The POS indicated the resident was to receive lidocaine/prilocaine (EMLA) cream (a skin numbing cream) to the left upper extremity fistula 45 to 60 minutes prior to dialysis, and the right subclavian access site was to be checked every shift.</p> <p>Review of the record indicated the resident underwent fistula revision</p>	R 0241	<p>1) Resident #4 was assessed & orders placed for monitoring AV fistula on 3/8/16.2) All other residents with fistulas have potential be affected by this alleged deficiency. All residents with fistulas assessed for orders & monitoring in place.3) Licensed nurses will be re-educated on monitoring & assessing shunts. DON or designee will monitor documentation regarding shunt assessment 2x's per week x 6 months.4) QAA will monitor findings for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly x 6 months or until 100% compliance is achieved.</p>	04/07/2016

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	<p>surgery to the left upper extremity on 12/28/15.</p> <p>Review of the 3/2016 Treatment Administration Record indicated the resident's right subclavian dialysis access site was monitored every shift. The record lacked documentation the fistula site had been assessed or monitored.</p> <p>Interview with LPN #1 on 3/8/16 at 10:10 a.m., indicated staff monitored the right subclavian access site so she thought that was the access site the resident had been using at dialysis.</p> <p>Interview with LPN #2 on 3/8/16 at 10:12 a.m., indicated the resident used both dialysis access sites. She indicated the resident was in the process of transitioning to using the fistula but some days dialysis would still use the right subclavian access. She further indicated, staff had looked at the fistula but she didn't think there was an order to assess it and didn't think it was documented anywhere.</p> <p>A facility policy, titled "Guidelines for Monitoring Shunt: Hemodialysis Arteriovascular Access (AV) (Fistula, Graft or Central Venous Catheter)", dated 6/2015 and received from the Administrator as current, indicated "...1.</p>			

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	Monitor AV shunt daily for: redness, swelling, signs and or symptoms of infections, complaints of pain, local warmth, exudate, tenderness, numbness, tingling, extremity swelling distal to access...2. Monitor the AV shunt daily for thrill and bruit...6. Document assessment findings in the resident medical record nursing notes and or in designated area on treatment administration record (TAR)...."				