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 05/29/2014

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

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F000000	This visit was for the Investigation of Complaint IN00149642. Complaint IN00149642- Substantiated. Fereral/state deficiency related to the allegation was cited at F323. Survey dates: May 29, 2014 Facility number: 012355 Provider number: 155782 AIM number: 201014410 Survey team: Regina Sanders, RN-TC Census bed type: SNF: 43 SNF/NF: 15 Residential: 34 Total: 92 Census Payor type: Medicare: 20 Medicaid: 15 Other: 57 Total: 92 Sample: 4	F000000	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. White Oak Health Campus requests a desk review with paper compliance be considered in establishing the provider is in substantial compliance. We appreciate your consideration of this request.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on June 2, 2014, by Janelyn Kulik, RN.			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a resident received adequate supervision and assistance devices to prevent accidents, related to not informing residents the call lights were not working, which led to a	F000323	1. Resident #B no longer resides at the facility. 2. All residents have the potential to be at risk for the alleged deficiency. Director of Health Services (DHS) in-serviced nursing staff on proper rounding when the call	06/27/2014

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	resident falling in the bathroom, for 1 of 3 residents reviewed for falls and 1 resident interviewed for call light usage, in a total sample of 4. (Resident #B) Findings include: 1. Resident #B's closed record was reviewed on 05/29/14 at 9:50 a.m. The resident's diagnoses included, but were not limited to, pneumonia and hypertension. The resident was discharged to home from the facility on 03/31/14. A 14 Day Minimum Data Set (MDS) Assessment, dated 03/07/14, indicated the resident's cognition was intact, required supervision with transfers, ambulation, and toileting, standing balance was not steady but the resident was able to stabilize without assistance, and had no history of falls. An Undated, Individual Plan Report, received as current for the time of the incident from the DoN (Director of Nursing), indicated the resident was a risk for falls related to weakness. The plan indicated the resident needed to remember to wait for assistance when she used her call light. A Nurses' Note, dated 03/12/14 at 4 p.m.,		light system is inopperable on 3/13/14. Director of Plant Operations (DPO)ordered additional calls bells on 3/13/14. Call bells were placed in supply closets at each nurses station on 3/14/14. Call light vendor, Vanguard, returned to the facility on 3/14/14 and replaced the system batteries as a precautionary measure. 3. Staff will be in-serviced by DHS or designee on 'Guidelines for Inopperable Call Light System' (see attached). DPO will conduct monthly mock drills related to an inopperable call light system to ensure guidelines are being followed. 4. Results from the mock drills will be brought to monthly Quality Assurance (QA) Meetings. QA Committee will review trends x 6 months or until 100% compliance is achieved.	

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	indicated, "Called to room via students. res (resident) was laying face first on bathroom floor. Stated she went to stand up & her foot was asleep...nose bruised...was sent to ER (Emergency Room)..." A Fall Circumstance, Assessment and Intervention form, dated 03/12/14 at 4 p.m., indicated the fall occurred in the bathroom, safety equipment was in place and functioning at the time of the incident, and prevention was to educate on the call light usage and to wait for staff prior to standing up. The IDT (Interdisciplinary Team) review, dated 03/14/14, indicated the resident did not wait on staff to help her before getting up. The IDT other comments indicated the call lights were down and the staff had been rounding on the unit. A Resident Concern Form, voiced by the resident's son, dated 03/13/14, indicated the incident date was 03/12/14. The concern indicated the call light system was not working and the resident had a fall while the system was not working. The staff were rounding but did not go in and tell the resident the system was not working and there was not a facility policy for when the call lights did not work. The area on the form which indicated, "What should we do so this			

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	situation does not reoccur? although call light was down (arrow down) resident didn't' wait for assist (assistance) after pulling BR (bathroom) call light, which obviously didn't work to notify the staff..." An Addendum to the Resident concern, dated 03/12/14 (sic-should have been 03/13/14), indicated the resident had been using the bathroom independently with a walker, all staff had been informed the call lights were not working and were conducting rounds and while completing rounds, the Student NA (Nurses Aide)/CNA #1 heard the resident yelling and entered her room to find the resident on the bathroom floor. The form further indicated the resident was alert and oriented x3 and was educated on waiting for assist, since rounds were being done she would have been checked on and assisted off toilet. Another factor was resident's feet were asleep causing her to fall. A statement written by the Student NA/CNA #1, no date written, indicated on March 12 when she arrived for work she was informed the call lights were not working and had checked on the residents every ten minutes. She indicated the resident was on the toilet and had complained of a stomach ache and she			

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	informed the resident she would let the nurse know and the Student NA continued to do room checks, and went to the opposite end of the hall and was heading back towards Resident #B's room when she heard the resident screaming for help. A typed and signed statement, dated 03/12/14, from the Director of Plant Operations (DPO), indicated about 2:30 p.m. he had been told nursing the system was down and to make sure they completed room checks. A written statement by CNA #2, dated 03/12/14, indicated she had been assisting another resident in the bathroom when Student NA/CNA #1 came and informed her LPN #3 needed her help. The statement indicated Resident #B was on the floor in her bathroom and Resident #B's walker was not in the bathroom. She indicated prior to the fall Student NA/CNA #1 and her had been on the hall and doing room checks due to the call system was down. During an interview on 05/29/14 at 9:55 a.m., Student NA/CNA #1 indicated she had been informed at 2 p.m. on 03/12/14 the call light system was not working. She indicated she started to do routine rounds and bells were placed with every			

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	resident. She indicated Resident #B had a bell placed in her bathroom and it was either sitting on the sink or on her walker. She indicated the resident was on the toilet around five minutes. During an interview on 05/29/14 at 10:55 a.m., the DoN (Director of Nursing) indicated the staff were informed immediately of the call light system not working and the staff started making rounds. She indicated she assumed the staff told the residents the call light system was not working but did not know for sure. She indicated she had found out after the call lights were fixed there were bells in the store room. She indicated the bells were not given out to the residents. She indicated again, she was not sure if the residents were informed the call light system was not working. She indicated she inserviced the staff after the fall to inform all staff and residents when the call light system was not working, staff to round every hour and to do 15 minute checks and to give bells to residents who are able to use the call light. She indicated the bells were in the DPO's office, but as of 03/14/14 there were now in the Supply Closets of each hall. During a telephone interview on 05/29/14 at 11:40 a.m., Resident #B indicated no one had informed her the call light			

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	system was not working. She indicated she had taken herself to the bathroom and left her walker outside the bathroom door. She indicated she had sat on the toilet for awhile and had pressed the call light twice and no one came to answer the light. She indicated when no one answered her light, she thought she would try to transfer herself off the toilet and she fell. She indicated her legs had fallen asleep. She indicated when the nurse was assisting her after the fall, a CNA came into the room and told the Nurse the call lights were working again, and that was the first she had heard the call lights were not working. During a telephone interview on 05/29/14 at 1:15 p.m., LPN #3 indicated Student NA/ CNA #1 had told her Resident #B complained of a stomach ache, she indicated she went and checked on Resident #B and told the resident she would be right back. She indicated Resident #B then attempted to transfer herself and fell. She indicated the resident's walker was in the bathroom and the resident had a little bell in the bathroom because the call lights were not working. She indicated Student NA/CNA #1 heard the resident yelling. LPN #3 indicated she had the staff checking rooms until she could get the bells in place. She indicated she had to			

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	get the bells from the DPO. She indicated she had the Student NA's (two on the unit) go and tell the residents the call lights were not working and the staff would be checking on them. During an interview on 05/29/14 at 1:20 p.m., the DPO indicated Nursing had informed him the call light system was not working. He indicated he informed the Nursing staff the call lights were not working on hallway 300 and to make sure rounds were completed. He indicated he had a few bells in his office, and to his knowledge they had not been handed out to the residents. He indicated he did not bring the bells out of his office. During an interview on 05/29/14 at 1:30 p.m., the Executive Director indicated the facility did not have and does not have a written policy for what to do if the call lights were not working. 2. During the initial tour on 05/29/14 at 9:10 a.m., LPN #4 identified Resident #E as alert and oriented times three and interviewable. A Resident Census Summary for 03/12/14, received from the Executive Director on 05/29/14 at 9:30 a.m. indicated Resident #E was a resident on the 300 Hall on 03/12/14.			

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	Resident #E's record was reviewed on 05/29/14 at 1:05 p.m. The resident's diagnoses were, but not limited to, kidney failure and hypertension. A Quarterly MDS Assessment, dated 03/27/14, indicated the resident's cognition was intact. During an interview on 05/29/14 at 12:25 p.m., Resident #E indicated he remembered the call lights not working. He indicated he was told the call lights had not been working after the call lights were fixed. Resident #E indicated he had not attempted to use the call light during the time they were not working. This Federal Tag relates to Complaint IN00149642. 3.1-45(a)(2)			