STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155782	A. BUILDING 00 B. WING	07/29/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaint IN00381754 and Nursing Home and Residential Complaint IN00381857. This visit included the Investigation of Residential Complaint IN00386025. Complaint IN00381754 - Substantiated. Federal/state deficiencies related to the allegations are cited at F840. Complaint IN00381857 - Substantiated. Federal/state deficiencies related to the allegations are cited at F677, F684, F759, F770, F840, F842, R0087 and R0240. Complaint IN00386025 - Substantiated. State deficiencies related to the allegations are cited at R0002, R0036, R0052, and R0240. Unrelated deficiencies are cited. Survey dates: July 27, 28, and 29, 2022 Facility number: 012355 Provider number: 155782 AIM number: 201014410 Census Bed Type: SNF/NF: 26 SNF: 30 Residential: 63 Total: 119 Census Payor Type: Medicare: 16 Medicaid: 30 Other: 10	F 0000		

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo 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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	Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/3/22.			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure residents who required extensive to dependent care received incontinent care in a timely manner, for 3 of 3 residents reviewed for incontinent care. (Residents G, F, and L) Findings include: 1. The following was observed for Resident G on 7/28/22: At 8:31 a.m., he way lying in bed and awake. There was a faint urine smell in the room. At 8:56 a.m., there was a urine smell in the hallway outside of the room. At 8:59 a.m., CNA 3 and CNA 4 entered the room. CNA 3 indicated there was a urine smell in the room. She indicated they started the shift at 6 a.m. They proceeded to start care on the resident. There was a wetness under the brief and a dried brown ring. There was incontinence of bowel and a large amount of wetness in the incontinent brief observed. CNA 4 indicated he was probably last	F 0677	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the	08/19/2022

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	checked for incontinence around 4 or 5 a.m. and he had not been checked since the beginning of the shift at 6 a.m. The bowel movement on the skin is dried. The wetness on the bottoms sheet went from the middle back to the middle thigh. There was no redness or excoriation to the buttock area. Incontinent care was completed and the bottom sheet was changed. Resident G's record was reviewed on 7/28/22 at 9:10 a.m. The diagnoses included, but were not limited to, cerebral ischemia and adult failure to thrive. A Quarterly Minimum Data Set (MDS) assessment, dated 7/6/22, indicated a severely impaired cognitive status, required extensive assistance of two for bed mobility, transfers, and toileting, and was always incontinent of bowel and bladder. A Care Plan, dated 1/27/22, indicated moisture related skin damage to the buttock. The interventions included to keep clean and dry. A Care Plan, dated 4/12/22, indicated an impairment of functional status in regards to bed mobility, transfers, toileting, and eating. The interventions included extensive assistance was needed for toileting. A Care Plan, dated 10/6/21, indicated there were episodes of incontinence. The interventions included assistance was needed for toileting as needed and incontinent care as needed. 2. The following was observed for Resident F on 7/28/22: At 9:47 a.m., Resident F was sitting in a Broda		department a desk review for substantial compliance. 1)Residents G, F and L were placed on a toileting schedule for before meals, after meals and before bed where they are laid down and checked at minimum every two hours. Residents F and L were assessed by the facility wound nurse immediately and physician notified for appropriate treatment orders as well as the residents responsible party was notified. The skin concerns identified on Resident F and L have since been healed. 2)All incontinent residents have the potential to be affected. A skin assessment of all incontinent residents was completed on the date of incident and no new skin areas were identified. C.N.A.'s 3, 4 and 5 were individually educated on the date of incident on proper incontinence, peri care and skin integrity. 3)All nursing staff in-serviced by the ED and DHS on ADL care for dependent residents including incontinence and peri-care policy. The ED, DHS or designee will complete rounds of five incontinent residents a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months to ensure that appropriate incontinence care is being provided. 4) Ongoing compliance with this corrective action plan will occur as	

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	(high back reclining chair) chair in front of the TV in the lounge. At 12 p.m., she was in the Dining Room sitting in the Broda chair. At 1:30 p.m., she was in the lounge sitting in the Broda chair by the Nurses' Station. At 1:47 p.m., CNA 3 and CNA 5 assisted the resident to her room and transferred her manually to the bed. CNA 3 indicated the resident had been checked and incontinent care had been given around 7 -7:30 a.m. when she was assisted out of bed. CNA 5 indicated residents were usually checked for incontinency in the morning, after breakfast, and before lunch. She had been in activities this morning so she had not been checked. The incontinent brief was wet. There was a pin point open area observed to the right buttock. Incontinent care was completed. No barrier cream was used. A new incontinent brief was applied. Resident F's record was reviewed on 7/28/22 at 5:03 p.m. The diagnoses included, but were not limited to, stroke and dementia. A Quarterly MDS assessment, dated 7/8/22, indicated a short and long term memory problem, required extensive assistance of two for transfers, bed mobility, and toileting, and was always incontinent of bowel and bladder. A Care Plan, dated 7/12/22, indicated incontinence. The interventions included assistance with toileting would be offered and incontinent care would be completed as needed. An interview on with the Administrator on 7/28/22		the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5) 8/19/2022	

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	at 5:36 p.m., indicated the resident was in a group reading activity from 8:15 a.m. to 8:30 a.m. and received an one on one activity in the lounge by the Nurses' Station from 8:30 a.m. to 8:45 a.m. The Administrator indicated on 7/28/22 at 5:38 p.m., the resident had not been activities all morning and could have been toileted. 3. During an observation on 7/28/22 at 1:33 p.m., CNA 3 and CNA 5 assisted Resident L from the wheelchair to the bed with the use of a mechanical lift. The incontinent brief was saturated with urine. CNA 3 indicated the last check for incontinence was around 8:30 a.m. Incontinent care was completed. There was a small open area observed on the right buttock and the right buttock had an area which was pink. Resident L's record was reviewed on 7/29/22 at 12:50 p.m. The diagnoses included, but were not limited to, diabetes mellitus and dementia. A Quarterly MDS assessment, dated 5/27/22, indicated a severely impaired cognitive status. Required extensive assistance of two staff for bed mobility, transfers, and toileting, was frequently incontinent of bowels and always incontinent of bladder. A Care Plan, dated 11/25/20 and reviewed on 6/8/22, indicated episodes of incontinence. The interventions included offers and assistance with toileting would be provided as needed. A Care Plan, dated 11/25/20 and reviewed on 6/8/22, indicated a risk for skin breakdown. The interventions included to keep clean as possible and minimize skin exposure to moisture.			

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	The Administrator was informed of the observation on 7/28/22 at 5:38 p.m. This Federal tag relates to Complaint IN00381857. 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure treatments and care was provided in accordance with professional standards of practice, related to treatments of medicated ointments completed without a Physician's Order, dressings applied without a Physician's Orders, and assessments of the areas not completed, for 2 of 11 residents reviewed for quality of care. (Residents K and E) Findings include: 1. During an interview on 7/28/22 at 11:25 a.m., RN 6 indicated Resident K had a PICO (single use negative pressure wound therapy system that runs for seven days and shuts off) on the surgical site located on the buttocks. She indicated the PICO had stopped running and they were applying Santyl (debridement agent) to the area and packing the wound with gauze. She indicated there was no Physician's Order for this treatment.	F 0684	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all	08/19/2022

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	They had been using this treatment prior to PICO usage. She indicated the Wound Nurses thought this would be the best treatment until another PICO could be obtained. She indicated the PICO had been off for a few days. During an observation on 7/28/22 at 11:41 a.m., there was no dressing on the upper buttock wound. RN 6 indicated the dressing had come off. She indicated the wound had slough and there was an infection in the wound. She then cleaned the wound with normal saline, placed Santyl in the wound and indicated a nickel thick amount was to be applied. She then packed the wound with gauze and placed a foam dressing over the area. She then indicated she was going to look to see if there was another PICO in the building that could be used. A Physician's Order, dated 7/23/22, indicated the Santyl had been discontinued. A Physician's Order, dated 7/26/22 as a one time order, indicated the PICO dressing was to be changed and the PICO would shut down either 7/26/22 or 7/27/22 automatically. The Medication Administration Record, dated 7/2022, indicated the PICO was removed on the 6 p.m. to 6 a.m. shift due to urine and was not on during the 6 p.m. to 6 a.m. shift on 7/27/22 due to there was no PICO, foam dressing or packing available. A Physician's order for a treatment due to the PICO not being on was not obtained until 7/28/22 at 9:38 p.m. and indicated to loosely pack the area with collagen and cover with a dressing every four days.		state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. **1)**Resident K had no adverse effects as a result of the deficient practice. Resident's physician was notified, and appropriate treatment orders were obtained, no worsening of the wound was noted. Resident E had no adverse effects as a result of the deficient practice. Resident's skin tear was assessed on 7/28/2022 and wound was healed, appropriate documentation in place. 2)All other residents that have skin tears/lacerations have the potential to be affected by the same deficient practice. An audit of all other residents that have current skin tears and/or physician orders for skin treatments was completed to ensure that an order for the correct treatment is in place and that they have been assessed weekly. 3)All nursing staff educated on 8/19/2022 on ensuring that treatment orders are in place for all resident wound treatments, ensuring that the physician has given orders on appropriate treatment in the event that the PICO is removed and unable to be put back on, ensuring that the physician is notified of any	

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	There was no documentation in the Nurses' Progress Notes that indicated when the PICO was discontinued and what treatment was in place when the PICO was no longer used. During an interview on 7/29/22 at 2:30 p.m., the Director of Nursing (DON) indicated there was no documentation on what the facility had done or when the PICO was discontinued. The Corporate RN indicated on 7/26/22 the area was packed loosely with Acticoat (antimicrobial dressing). The area was to be re-assessed so a decision could be made if the PICO needed to be replaced. During an interview on 7/29/22 at 2:51 p.m., LPN 7 indicated another nurse had packed the wound and applied a foam dressing. She was unsure what it was packed with. She indicated she packed the wound with normal saline gauze. There had not been an order for another treatment, so she applied whatever dressing was used before. She thought the other nurse had notified the Physician. There had not been an order for a treatment to the wound after the PICO was discontinued. 2. During an observation on 7/28/22 at 4:14 p.m., Resident E had a dressing on the back of his left hand dated 7/28/22. He indicated the dressing was changed daily. Resident E's record was reviewed on 7/28/22 at 2:04 p.m. The diagnoses included, but were not limited to, stroke. An Event Form, dated 7/15/22 at 7:06 p.m., indicate a skin tear to the back of the left hand due to a fall. A border dressing was applied. The area measured 1.5 cm by 1.5 cm, was shallow with a moderate amount of blood. The skin tear had		changes in wounds/concerns with treatments, ensuring that the physician is notified and documentation is in place when a treatment is changed, the facility policy for skin tear assessment guidelines that includes ensuring that physician notification and treatment orders are obtained for all skin tears as well as that they are assessed at minimum of one time a week per the policy. The DHS or designee will complete audits to ensure that all skin concerns have orders and all skin concerns are assessed at least weekly in addition to observations to ensure that the treatments that are being performed align with the current physician order a minimum of 5 times weekly for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months. 4) Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5) 8/19/2022	

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	irregular edges. There was no Physician's Orders for a treatment for the skin tear or when the dressing should be changed. There was no further assessment of the skin tear. During an interview on 7/28/22 at 4:17 p.m., the Director of Nursing indicated there was no Physician's Order for the dressing and when to change the dressing. There were no further assessments of the skin tear area since the area was first found. A facility policy for skin tear assessment guidelines, dated 5/10/16 and received from the Director of Nursing as current, indicated a weekly follow-up assessment may be completed to ensure the skin tear is resolved or in the process of healing. This Federal tag relates to Complaint IN00381857. 3.1-37			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent			

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	with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure care was provided to assist in preventions of pressure ulcers, related to incontinence care and repositioning, for 2 of 2 residents reviewed for pressure ulcers. (Residents F and L) Finding includes: 1. Resident F was observed on 7/28/22 sitting in a Broda (high back recliner) chair from 9:47 a.m. through 1:47 p.m. At 1:47 p.m., CNA 3 and CNA 5 assisted the resident to her room and transferred her manually to the bed. CNA 3 indicated the resident had been checked and incontinent care had been given around 7 -7:30 a.m. when she was assisted out of bed. CNA 5 indicated residents were usually checked for incontinency in the morning, after breakfast, and before lunch. She had been in activities this morning so she had not been checked. The incontinent brief was wet. There was a pin point open area observed to the right buttock. Incontinent care was completed. Resident F's record was reviewed on 7/28/22 at 5:03 p.m. The diagnoses included, but were not limited to, stroke and dementia. A Quarterly MDS assessment, dated 7/8/22, indicated a short and long term memory problem, required extensive assistance of two for transfers, bed mobility, and toileting, was always incontinent of bowel and bladder, and had no pressure ulcers.	F 0686	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1)Residents F and L were assessed by the facility wound nurse immediately and physician notified for appropriate treatment orders as well as the residents responsible party was notified. The skin concerns identified on Resident F and L have since been	08/19/2022

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	A Care Plan, dated 7/12/22, indicated a risk for skin breakdown. The interventions included, assistance in repositioning would be provided as needed, she would be kept dry and clean, risk for moisture would be minimized on the skin and a barrier cream would be used as needed. An Event Form, dated 7/28/22 at 2:26 p.m., indicated there was an open area to the upper right coccyx area. It was round, red, and had scant serosanguinous drainage. The area measured 0.1 centimeters (cm) by 0.1 cm with a depth of less than 0.1 cm. A Wound Assessment Progress Note, dated 7/29/22 at 11:04 a.m., indicated the wound presented as moisture associated skin damage. The Physician and Representative were notified and an order for skin barrier cream twice a day was received. 2. During an observation on 7/28/22 at 1:33 p.m., CNA 3 and CNA 5 assisted Resident L from the wheelchair to the bed with the use of a mechanical lift. The incontinent brief was saturated with urine. CNA 3 indicated the last check for incontinence was around 8:30 a.m. Incontinent care was completed. There was a small open area observed on the right buttock and the right buttock had an area which was pink. Resident L's record was reviewed on 7/29/22 at 12:50 p.m. The diagnoses included, but were not limited to, diabetes mellitus and dementia. A Quarterly MDS assessment, dated 5/27/22, indicated a severely impaired cognitive status. Required extensive assistance of two staff for bed mobility, transfers, and toileting, was frequently incontinent of bowels, always incontinent of		healed. 2)All incontinent residents are at risk for potential skin impairment and to be affected. A skin assessment of all incontinent residents was completed on the date of incident and no new skin areas were identified. Skin assessments of fifteen residents will be completed monthly for six months, and appropriate action taken if needed. 3)All nursing staff in-serviced by the ED and DHS on incontinence care, maintaining resident skin integrity and repositioning. All nursing staff in-serviced on incontinence care, use of barrier cream, turning/repositioning and noting compromised skin areas to the nurse immediately. The Nurse Managers will complete skin assessments of all incontinent residents monthly for six months. The ED, DHS or designee will complete rounds on ten incontinent residents a week for 4 weeks, ten incontinent residents every other week for 4 weeks, ten residents a month for 4 months to ensure that appropriate incontinence care is being provided and turning/repositioning has occurred. 4)Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bladder, and no pressure ulcers. A Care Plan, dated 11/25/20 and reviewed on 6/8/22, indicated a risk for skin breakdown due to incontinency. The approaches included, moisture barrier products as needed, assist to reposition, keep skin clean and dry, and minimize skin exposure to moisture. A Nurse's Progress Note, dated 7/28/22 at 3:42 p.m., indicated an open area to right upper outer coccyx was found. The area was cleaned. The resident was placed on her left side. The Representative and the Physician were notified. A Nurse's Progress Note, dated 7/29/22 at 11 a.m., indicated the wound was assessed on the buttock and presented as moisture associated skin damage due to incontinence. Skin barrier cream was ordered twice a day. A facility policy for pressure prevention, dated 12/1/21, and received from the Corporate RN as current, indicated the skin was to be kept clean, dry and free of body wastes. 3.1-40(1)		discontinued after 6 months if no further concerns are identified. 5) 8/19/2022	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			

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	155782	A. BUILDING 00 B. WING	07/29/2022

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	Based on observation, record review, and interview, the facility failed to ensure a resident received use of assistive devices to decrease her chance of accidents, related to a resident who was care planned for a mechanical lift transfer being transferred manually, for 1 of 2 residents observed for transfers. (Resident F) Finding includes: During an observation on 7/28/22 at 1:47 p.m., CNA 3 and CNA 5 transferred Resident F from the Broda chair (high back reclining chair) to the bed. They each placed an arm under the resident's arm/shoulder area and used the back of the resident's pants to assist her to a standing position, then pivoted her to the bed and assisted her into a lying position. A Care Plan, dated 6/14/21, indicated a risk for falls and a mechanical lift could be used for transfers. The CNA Profile Care Guide, dated 3/23/22, indicated she was dependent for transfers and a mechanical lift was to be used for transfers. During an interview on 7/28/22 at 5:22 p.m., the Corporate RN indicated the CNA's should use the Care Guide for resident care and acknowledged a mechanical lift should have been used for the transfer. 3.1-45(2)	F 0689	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1)Resident F was assessed by a licensed nurse and no skin concerns or adverse effects from transferring her with two people was noted. The physician was notified of resident's order that she may be transferred with a mechanical lift or via two staff members; order was clarified that resident should be transferred with two staff members via a gaitbelt	08/19/2022

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			and may transfer using a mechanical lift was discontinued. 2)All other residents that are transferred with a mechanical lift have the potential to be affected. All review of each resident's physician orders was completed to ensure that the resident care guide reflects that they are a mechanical lift as well as their plan of care. A skin assessment on each resident that is ordered the use of a mechanical lift has been completed. 3)All nursing staff educated on 8/19/2022 on following physician orders/careguides for resident transfers as well as on the Gait Belt policy. Each resident room for appropriate residents has been stocked with a gait belt. All nursing staff educated on following physician orders for resident transfers and following resident careguides for transfers. The ED, DHS or designee will complete observations of transfers to ensure that the physician order is followed: five residents a week for 4 weeks, five residents every other week for 4 weeks and five residents a month for 4 months to ensure that appropriate resident transfers are being provided. 4)Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be	

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			discontinued after 6 months if no further concerns are identified. 5)8/19/2022	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 5 residents observed during 4 medication pass observations. 3 errors in medications were observed during 26 opportunities for errors in medication administration. This resulted in a medication error rate of 11.53. (Residents N, O, & P) Findings includes: 1. RN 6 was observed on 7/28/22 at 8:10 a.m. She was preparing Resident N's morning medications. She placed the following medications in the plastic medication cup: aspirin 81 mg (milligrams), 1 tablet B12, one tablet cranberry 450 mg, one tablet donepezil (cognitive enhancer) 5 mg, two half tablets ferrous sulfate (iron), 325 mg, one tablet levothyroxine (thyroid) 50 micrograms, one tablet loratadine (allergy) 10 mg, one tablet metoprolol (losartan, blood pressure) 25 mg, one tablet potassium 10 milliequivalent, one tablet sertraline (antidepressant), 50 mg, one tablet vitamin C 250 mg, one tablet.	F 0759	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1)Resident N, O, and P were	08/19/2022

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	She indicated there were 12 tablets in the cup, then proceeded into the resident's room and administered the medications. The resident requested a pain medication at that time, the pain was assessed, and then a hydrocodone (pain) 7-325 mg tablet was given. Resident N's record was reviewed on 7/29/22 at 10 a.m. A Physician's Order, dated 6/10/22, indicated losartan 25 mg tablets, administer 1 1/2 tablets daily between 6 a.m. and 10 a.m. The losartan had not been administered. 2. During an observation on 7/28/22 at 11:02 a.m., RN 6 prepared Resident O's intravenous (IV) of cefepime (antibiotic) 1 gm (gram). The cefepime was mixed with 50 milliliters (ml) of 0.9% normal saline. The Physician's Order, reviewed at the time of the medication being prepared, indicated the cefepime was to be mixed with 50 ml. of dextrose. RN 6 indicated the pharmacy recommended normal saline be used for the infusion and had not clarified this with the Physician as of that time. She indicated normal saline had been used for the infusion since the medication was ordered on 7/18/22. The Physician's Order, dated 7/18/22, indicated the cefepime was to be mixed with 50 ml of dextrose and was to be administered twice a day. 3. During a medication pass observation on 7/29/22 at 10:32 a.m., the Corporate Regional RN administered 1.8 mg of Victoza (antidiabetic) subcutaneous via pen to Resident P.		observed for 72 hours post med pass and had no negative affects r/t the deficient practice. 2)All residents that reside in the facility and have physician orders for medications to be administered by the facility staff have the potential to be affected by the deficient practice. Medication pass audits will be completed by the DHS and/or designee and individual education will be completed as needed. 3)All Nurse's educated on following physician orders for medication pass, ensuring that the 5 Rights of Nursing Administration are followed, clarifying physician orders for pharmacy interchanges as well as the medication administration time policy. The ED, DHS or designee will complete medication administration observations for ten residents every week for 4 weeks, ten residents every other week for 4 weeks and then ten residents weekly for 4 months and present any concerns at the monthly QAPI meeting. 4)Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5)8/19/2022	

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	Resident P's record was reviewed on 7/29/22 at 11:15 a.m. The Physician's Order, dated 4/21/22, indicated 1.8 mg was to administered via pen daily, between 6 a.m. and 10 a.m. A Medication Administration policy, dated 11/2018 and received from the Administrator as current, indicated, the five rights of medication administration were to be followed, the five rights included, right drug, right dose, and right time. Medications were to be administered in accordance with the written orders of the prescriber. This Federal tag relates to Complaint IN00381857. 3.1-25(b)(9) 3.1-48(c)(1)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on record review and interview, the facility failed to ensure a resident was provided with laboratory service related to a laboratory blood test not completed as ordered for 1 of 3 residents reviewed for laboratory services. (Resident G) Finding includes: Resident G's record was reviewed on 7/28/22 at 9:10 a.m. The diagnoses included, cerebral	F 0770	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of White Oak Health Campus. The facility recognizes	08/19/2022

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	ischemia and adult failure to thrive. A Physician's Order, dated 6/3/22, indicated a complete blood count (CBC) and a complete metabolic profile (CMP) was to be completed on 6/10/22. A Nurse's Progress Note, dated 6/13/22 at 3:41 p.m., indicated the laboratory company was unable to obtain the blood for the CBC and CMP on 6/10/22 and on 6/13/22. The laboratory specimen would be attempted on the next laboratory draw day. There was no documentation that indicated the Physician had been notified about the test not completed. There was no documentation that indicated the test was attempted on the next laboratory draw day. A CBC and CMP was completed on 6/20/22. During an interview on 7/28/22 at 2:37 p.m., the Director of Nursing (DON) indicated the normal laboratory draw days are Monday, Wednesday, and Friday. She indicated the laboratory test had not been completed on those days. She indicated the Physician had also not been notified the tests were not completed as ordered. This Federal tag relates to Complaint IN00381857. 3.1-49(c)		its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1)Resident G had no adverse effects from the deficient practice, their labs were drawn on 6/20/2022 and no concerns noted; resident's physician was notified that the labs were completed on 6/20/2022 instead of 6/10/2022 and follow up labs completed with no new concerns. 2)All other residents that have physician orders for laboratory draws have the potential to be affected by the same deficient practice. A review of the last 14 days of labs completed to ensure completion and appropriate physician notification. 3)All nursing staff educated on 8/19/2022 on the lab procedure including notifying the physician of any labs that are not drawn on the date of the physician order and	

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			new physician orders to be obtained as appropriate. The DHS or designee will complete laboratory audits to ensure that labs are drawn on the date ordered by the physician as well as physician notification is completed timely at a minimum of 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months and any concerns presented at the monthly QAPI meeting. 4)Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5)8/19/2022	
F 0840 SS=D Bldg. 00	483.70(g)(1)(2) Use of Outside Resources §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside			

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	resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. Based on record review and interview, the facility failed to ensure outside resources were used as ordered, related to a resident with a consult appointment to see a Neurosurgeon not provided transportation to the appointment for 1 of 3 residents reviewed for outside resources visits. (Resident E) Finding includes: Resident E's record was reviewed on 7/28/22 at 2:04 p.m. The diagnoses included, but were not limited to, stroke. A Physician's Order, indicated the resident had a consult appointment with a Neurosurgeon on 7/7/22. There was no documentation to indicate the resident had gone to the appointment. A Nurse's Note, dated 6/23/22 at 4:18 p.m., indicated the resident said he would arrange his own transportation to the appointment on 7/7/22. There was no follow up with the resident to ensure he was able to find his own transportation to the appointment. During an interview on 7/28/22 at 4:17 p.m., the Administrator indicated she was not sure if he went to the appointment on 7/7/22. The appointment had been written on the calendar but	F 0840	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1)Resident E had no adverse effects as a result of the deficient practice. Resident E's missed appointment was rescheduled for 8/11/2022 in which resident went	08/19/2022

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	it did not indicate if he went to the appointment. RN 6 had indicated to the Administrator she was unsure if the resident had gone to the appointment on 7/7/22. The resident informed the Administrator he had not gone to the appointment but he was unsure why he didn't go. No one was sure why he did not go to the appointment. She indicated the bus was available for him to take. The Nurses' should document when residents left and returned from appointments or why they were not going to the appointments. She indicated she would call the Physician's Office to see if he went to the appointment or not. During an interview on 7/29/22 at 11:22 a.m., the Administrator indicated she notified the Physician's office and he had not gone to the appointment. She was still unsure why, but indicated the appointment had been rescheduled. This Federal tag relates to Complaints IN00381754 and IN00381857. 3.1-13(m)		to the appointment. 2)All other residents that have scheduled physician appointments have the potential to be affected by the same deficient practice. An audit of all residents with appointments in the last 30 days will be completed to ensure that resident was at appointment, documentation in place of appointment or appointment is rescheduled. An audit of all residents with appointments in the next 30 days reviewed to ensure that transportation is scheduled and physician order in place. 3)Transportation Assistant educated on the transportation policy. All nursing staff educated on 8/19/2022 on ensuring that transportation is scheduled for all resident appointments either thru the facility bus or an outside resource, ensuring that it is documented in the resident's chart if they go to the appointment as well as a reason if they do not go to the appointment and if it is rescheduled as appropriate. All resident appointments and transportation arrangements will be put in one calendar book and kept at a centralized location. The Transportation Assistant and/or designee will check the calendar three times a week to ensure that transportation is scheduled. The Executive Director, DHS or designee will complete audits of the physician appointments to	

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			ensure that transportation is scheduled, and documentation has occurred for appointments at a minimum of 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months and any concerns presented at the monthly QAPI meeting. 4)Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5)8/19/2022	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and			

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	(iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident;			

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	(ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure the resident's record was accurate and complete, related to an anticoagulant (warfarin) medication given and not documented as given, for 1 of 11 residents reviewed for medical records. (Resident G) Finding includes: Resident G's record was reviewed on 7/28/22 at 9:10 a.m. The diagnoses included, but were not limited to, cerebral ischemia and adult failure to thrive. A Physician's Order, dated 6/21/22 to 6/28/22, indicated to give warfarin 6 mg (milligrams) on Tuesdays and 4 mg on Sunday, Monday, Wednesday, Thursday, Friday, and Saturday. The Medication Administration Record (MAR), dated 6/2022, indicated warfarin 6 mg had not been administered on 6/21/22. The order for the warfarin 6 mg was not on the MAR. During an interview on 7/28/22 at 2:37 p.m., the Director of Nursing indicated the order for the warfarin 6 mg was not put in the computer correctly so it had been left off the MAR. During an interview on 7/29/22 at 11:24 a.m., the	F 0842	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1)Resident G had no adverse effects from the deficient practice,	08/19/2022

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	155782	A. BUILDING 00 B. WING	07/29/2022

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	Director of Nursing indicate she had spoken to Nurse 8, who confirmed she had given two tablets of the 3 mg warfarin tablets and had not documented anywhere the medication had been given since it was not on the MAR. A medication administration policy, dated 11/2018 and received from the Administrator as current, indicated the individual who administered the medication dose was to record the medication as administered on the MAR directly after the medication was given. This Federal tag relates to Complaint IN00381857. 3.1-(a)(1) 3.1-(a)(2)		he received the correct dose of medication however such was not documented correctly on his MAR. 2)All other residents whom are prescribed Coumadin have the potential to be affected by the same deficient practice. An audit of all other residents that receive coumadin will be completed to ensure that they have appropriate physician orders in place, that they are signed out on the MAR and that the physician is notified appropriately. 3)All nursing staff educated on the medication administration policy and entering coumadin orders in correctly into the EMAR.The DHS or designee will complete audits to ensure that coumadin orders are being given as ordered and entered correctly in the EMAR at a minimum of 5 times weekly for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months. 4)Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5)8/19/2022	

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R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00386025 and Nursing Home and Residential Complaint IN00381857. This visit included the Investigation of Nursing Home Complaint IN00381754. Complaint IN00386025 - Substantiated. State deficiencies related to the allegations are cited at R0002, R0036, R0052, and R0240. Complaint IN00381857 - Substantiated. Federal/state deficiencies related to the allegations are cited at F677, F684, F759, F770, F840, F842, R0087 and R0240. Complaint IN00381754 - Substantiated. Federal/state deficiencies related to the allegations are cited at F840. Survey dates: July 27, 28, and 29, 2022 Facility number: 012355 Residential Census: 63 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/3/22.	R 0000		
R 0002 Bldg. 00	410 IAC 16.2-5-0.5(b) Scope of Residential Care - Offense (b) A residential care facility may not provide comprehensive nursing care except to the extent allowed under this rule. Based on record review and interview, the facility failed to ensure a resident was not provided	R 0002	The submission of this plan of correction does not indicate an	08/19/2022

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	comprehensive nursing care, related to wound care treatment in the Assisted Living Memory Care Unit, for 1 of 3 residents reviewed for wound care treatments. (Resident B) Finding includes: Resident B's record was reviewed on 7/27/22 at 12:27 p.m. The diagnoses included, but were not limited to, dementia. The Nurses' Progress Notes indicated: On 4/2/22 at 10:49 a.m., the bilateral lower extremities were red, warm, inflamed, and painful. There was yellow exudate present. The Nurse documented, "suspecting cellulitis" The Physician was faxed the information. On 4/2/22 at 11:45 a.m., an order for an antibiotic for five days was received from the Nurse Practitioner. On 4/7/22 at 4:47 p.m., another order was received to continue the antibiotic for three additional days and Tylenol 650 mg (milligrams) was to be given twice a day for discomfort. Daily dressing changes were to be continued. Yellow exudate was observed on the the lower extremity dressings. On 4/13/22 at 8:50 p.m., the Nurse Practitioner was again notified due to continued redness, edema and scant drainage. The Nurse Practitioner suspected stasis dermatitis on the lower extremities and ordered bag balm (ointment) to the bilateral lower extremities. On 5/10/22 at 4:04 a.m., the bilateral lower extremities were weeping.		admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1)Resident B was discharged from the facility on 7/26/2022 to the hospital and will not be returning to the facility. 2)All other residents receiving comprehensive care on the assisted living unit potential to be affected by the same deficient practice. An audit of all other residents that resident on the Assisted Living Unit was completed to ensure that comprehensive services were not provided by the Assisted Living	

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	On 6/25/22 at 12 p.m., an infection of the of bilateral lower extremities continued. there was yellow and greenish exudate on the dressings. On 7/16/22 at 12:52 p.m., there was green drainage present on the bilateral lower legs. The areas were red and warm to touch. An order was received for an antibiotic for 10 days. On 7/16/22 at 8:32 p.m., the resident complained of "a little" amount of pain when the bilateral lower extremities were cleaned. After the areas were cleaned, Santyl (debriding agent) ointment was applied to the areas. The lower legs were then dressed and wrapped with roll gauze. On 7/21/22 at 3:41 p.m., a new treatment for the bilateral lower extremities was received. The legs were to be cleansed and then acticoat (antimicrobial barrier dressing) was to be applied and covered with abdominal pads and wrapped with roll gauze every three days and as needed. On 7/26/22 at 11:23 a.m. , the bilateral lower extremity dressings had a large amount of green and yellow drainage. The family requested the resident be transferred to the hospital. On 7/26/22 at 2:04 p.m., the family transported the resident to the hospital. The Physician's Orders were as follows: 4/3/22 to 4/7/22, Bactrim DS (antibiotic), 800-160 mg twice a day for cellulitis. 4/7/22 to 4/10/22, Bactrim DS 800-160 mg twice a day for five days. 4/13/22 to 4/21/22, bag balm to bilateral lower extremities twice a day until healed. 4/21/22 to 6/9/22, bag balm to bilateral lower extremities daily until healed and as needed.		staff. 3)The Executive Director, Director of Health Care Services, Community Services Representative, Community Service Specialist were educated by the DVP on ensuring that comprehensive care is not provided on an Assisted Living unless provided by an outside entity or separate staff from the Assisted Living staff. The ED or designee will audit any new admissions to the Assisted Living Unit 5 times weekly for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months to ensure that no 4) Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5) 8/19/2022	

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	6/9/22 to 6/17/22, Minerin cream (moisturizing cream), to the bilateral lower extremities after the areas were cleansed and dried. Then four non-adhesive pads were to be applied and wrapped with roll gauze daily. 6/17/22 to 6/28/22, Minerin cream was to be applied twice a day to the bilateral lower extremities. 6/23/22 to 7/16/22, Santyl ointment was to be applied to the bilateral lower extremity open areas after they were cleansed daily. 7/16/22 to 7/26/22, cephalexin (antibiotic) 500 mg three times a day. 7/16/22 to 7/21/22, Santyl ointment was to be applied to the open areas twice a day. 7/21/22, the bilateral lower legs were to be cleansed and acticoat was to be applied to the open areas every three days. During an interview on 7/27/22 at 10:30 a.m., the Administrator indicated the nurses at the facility had completed the treatments and was unaware Comprehensive Nursing Care was not to be completed in the Assisted Living areas of the facility by facility staff. During an interview on 7/27/22 at 3:28 p.m., the Director of Nursing indicated they had been providing comprehensive care to the resident. A facility Assisted Living wound care policy, dated 8/11/16 and received from the Administrator as current, indicated the resident would be evaluated every seven days to determine if nursing home or other appropriate health care was required. This Residential tag relates to Complaint IN00386025.			

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R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure a resident's Physician and Representative were notified or notified timely of changes in condition. related to bilateral lower extremity (BLE) status/wounds and falls, for 1 of 3 residents reviewed for Physician and Representative notification. (Resident B) Finding includes: Resident B's record was reviewed on 7/27/22 at 12:27 p.m. The diagnoses included, but were not limited to, dementia. Cross reference R0002 and R0052 for wounds, assessments, and provision of care. A Nurse's Progress Note, dated 5/10/22 at 4:04 a.m. indicated the BLE were weeping. The Nurses' Progress Notes had not indicated the Physician had been notified of the status of the BLE. The Nurses' Progress Notes, indicated the Resident Representative had not been notified of the status of the BLE and wounds until June 17, 2022.	R 0036	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	08/19/2022

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	A Nurse's Progress Note, date 6/25/22 at 12 p.m., indicated there was an infection in the BLE. Yellow and green exudate was present. The Nurses' Progress Notes, indicated the Physician and the Resident Representative had not been notified of the BLE status. A Nurse's Progress Note, dated 6/26/22, at 1:32 p.m., indicated the necrotic wound bed now had slough. The Nurses' Progress Notes indicated the Resident Representative had not been notified of the BLE status. A Nurse's Progress Note, dated 7/21/22 at 3:41 p.m., indicated a new treatment was ordered for the BLE. There was no documentation that indicated the family had been notified of the treatment change. A Nurse's Progress Note, dated 7/21/22 at 10:04 p.m., indicated the resident had chills, the forehead temperature was 100.4 and oral temperature was 98.6. There was no documentation the Physician and Resident Representative was notified of the change in condition. During an interview on 7/27/22 at 2:38 p.m., the Director of Nursing (DON) indicated the Representative had been notified on 4/2/22 and 6/17/22. No documentation of the Representative had been notified of the status until 7/16/22. During an interview on 7/27/22 at 3:05 p.m. the Assisted Living Director indicated she was unsure who had been notified on the BLE status.		1)Resident B was discharged from the facility on 7/26/2022 to the hospital and will not be returning to the facility. 2)All other residents residing on the assisted living unit whom have any status change have the potential to be affected by the same deficient practice. An audit of all residents whom have had a fall, treatment change or status change in the last 2 weeks has been reviewed to ensure that appropriate notification has taken place. 3)All nurse's will be educated on Resident Rights including resident and/or representative notification on status changes, falls, treatments and medication changes. The DHS or designee will audit all new changes in condition, falls, treatment changes and medication changes to ensure that family/responsible party notification has occurred 5 times weekly for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months to ensure that no comprehensive care is being provided by an in-house entity. 4)Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified.	

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	A Confidential Interview indicated there had been maggots found in the wounds on the BLE. During an interview on 7/27/22 at 3:16 p.m., LPN 1 indicated there definitely were maggots in the wounds. She had spoke with the family, though had not informed them about the maggots in the wounds. A Fall Event, dated 7/24/22 at 1:40 a.m., indicated the resident had an unwitnessed fall. The family had not been notified of the fall on 7/24/22. A communication policy for Assisted Living, dated 8/11/16 and received from the Administrator as current, indicated the purpose of the policy was to assure adequate information was provided to the residents and responsible party. They had a right to be made aware of changes. This Residential tag relates to Complaint IN00386025.		5)8/19/2022	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was free from neglect, related to not assessing a resident with open wounds to the bilateral lower extremities (BLE), which the resident had slough present in the wounds and possible maggots to the wounds. The facility also failed to ensure the resident was	R 0052	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and	08/19/2022

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	assessed by a Physician or Nurse Practitioner when the areas on the BLE deteriorated. The resident was admitted into the hospital with multiple chronic ulcerations, which had slough present, and were black and painful. (Resident B) Finding includes: Resident B's record was reviewed on 7/27/22 at 12:27 p.m. The diagnoses included, but were not limited to, dementia. The Nurses' Progress Notes indicated: On 4/2/22 at 10:49 a.m., the bilateral lower extremities were red, warm, inflamed, and painful. There was yellow exudate present. The Nurse documented, "suspecting cellulitis" The Physician was faxed the information. On 4/2/22 at 11:45 a.m., an order for an antibiotic for five days was received from the Nurse Practitioner. On 4/7/22 at 4:47 p.m., another order was received to continue the antibiotic for three additional days and Tylenol 650 mg (milligrams) was to be given twice a day for discomfort. Daily dressing changes were to be continued. Yellow exudate was observed on the lower extremity dressings. On 4/13/22 at 8:50 p.m., the Nurse Practitioner was again notified due to continued redness, edema and scant drainage. The Nurse Practitioner suspected stasis dermatitis on the lower extremities and ordered bag balm (ointment) to the bilateral lower extremities. There were no further assessments completed on the BLE areas until the documentation on 5/10/22 at 4:04 a.m.		living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1)Resident B was discharged from the facility on 7/26/2022 to the hospital and will not be returning to the facility. 2)All other residents whom have complex wounds on the assisted living unit have the potential to be affected by the same deficient practice. An audit of the last 14 days of progress notes completed to identify any chronic conditions whom required immediate intervention and/or physician assessment. 3)The DHS and/or designee will educate all nurse's on providing a wound assessment prior to obtaining new orders, ensuring that a physician order is in place	

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	On 5/10/22 at 4:04 a.m., the bilateral lower extremities were weeping There were no further assessments completed on the BLE areas until the documentation on 6/25/22 at 12 p.m. On 6/25/22 at 12 p.m., an infection of the of bilateral lower extremities continued. Tthere was yellow and greenish exudate on the dressings. There were no further assessments completed on the BLE areas until the documentation on 7/16/22. On 7/16/22 at 12:52 p.m., there was green drainage present on the bilateral lower legs. The areas were red and warm to touch. An order was received for an antibiotic for 10 days. On 7/16/22 at 8:32 p.m., the resident complained of "a little" amount of pain when the bilateral lower extremities were cleaned. After the areas were cleaned, Santyl (debriding agent) ointment was applied to the areas. The lower legs were then dressed and wrapped with roll gauze. There was no assessment of the BLE or of wounds prior to the Santyl orders initiated. On 7/21/22 at 3:41 p.m., a new treatment for the bilateral lower extremities was received. The legs were to be cleansed and then acticoat (antimicrobial barrier dressing) was to be applied and covered with abdominal pads and wrapped with roll gauze every three days and as needed. There were no further assessments of the BLE until 7/26/22 at 11:23 a.m. There was no documentation of the resident having wounds on		prior to providing any treatment, monitoring of any chronic condition as well as ensuring that physician appointments are made as needed. The DHS or designee will review Assisted Living resident nurse notes 5 times weekly for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months to ensure that appropriate action is taken. 4) Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5) 8/19/2022	

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	the BLE. On 7/26/22 at 11:23 a.m. , the bilateral lower extremity dressings had a large amount of green and yellow drainage. The family requested the resident be transferred to the hospital. On 7/26/22 at 2:04 p.m., the family transported the resident to the hospital. The Physician's Orders were as follows: 4/3/22 to 4/7/22, Bactrim DS (antibiotic), 800-160 mg twice a day for cellulitis. 4/7/22 to 4/10/22, Bactrim DS 800-160 mg twice a day for five days. 4/13/22 to 4/21/22, bag balm to bilateral lower extremities twice a day until healed. 4/21/22 to 6/9/22, bag balm to bilateral lower extremities daily until healed and as needed. 6/9/22 to 6/17/22, Minerin cream (moisturizing cream), to the bilateral lower extremities after the areas were cleansed and dried. Then four non-adhesive pads were to be applied and wrapped with roll gauze daily. 6/17/22 to 6/28/22, Minerin cream was to be applied twice a day to the bilateral lower extremities. 6/23/22 to 7/16/22, Santyl ointment was to be applied to the bilateral lower extremity open areas after they were cleansed daily. 7/16/22 to 7/26/22, cephalexin (antibiotic) 500 mg three times a day. 7/16/22 to 7/21/22, Santyl ointment was to be applied to the open areas twice a day. 7/21/22, the bilateral lower legs were to be cleansed and acticoat was to be applied to the open areas every three days. The Attending Physician or the Nurse Practitioner had not physically assessed the resident's BLE's			

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	155782	A. BUILDING 00 B. WING	07/29/2022

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	from 4/2/22 through 7/26/22. During an interview on 7/27/22 at 2:38 p.m., the Director of Nursing (DON) indicated a Wound Care Nurse at the facility had not been assessing the resident, though they had completed some of the treatments. All nurses were to assess the skin areas when they completed the treatments. The last Physician or Nurse Practitioner Progress Note was dated 3/2/22. The Hospital Emergency Room History and Physical, dated 7/26/22 at 3:02 p.m., indicated there was cellulitis on the BLE. The legs were red, warm, edematous, and had multiple chronic ulcerations with yellow purulent drainage. The diagnoses included, venous stasis dermatitis and venous stasis ulcers. The Hospital Wound Assessment Consult, dated 7/27/22, indicated the BLE's were red, had slough, were black and painful. The area on the right lower extremity was 21.2 centimeters (cm) by 29 cm with a depth of 0.1 cm. It was a full thickness wound with serosanguinous purulent drainage with 25% slough and 25% eschar. The left lower extremity was 16 cm by 28 cm with a depth of 0.1 cm. It was a full thickness wound with moderate serosanguinous purulent drainage. It had 25% slough and 25% eschar. A Confidential Interview, indicated there had been maggots found in the wounds on the BLE. During an interview on 7/27/22 at 2:38 p.m., the DON, indicated she was informed there were dark spots in the wounds and could not be positive they were maggots as she had not seen them. She indicated LPN 1 had notified her on 7/16/22 and said something was in the wounds and it was			

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	reported they had looked like maggots. LPN 1 had notified the Physician and received an order for an antibiotic. She had informed LPN 1 the wounds were to be cleaned with hydrogen peroxide. There were no Physician's Orders for the hydrogen peroxide to be used. LPN 1 had cleaned the areas with the hydrogen peroxide. She had not assessed the wounds. During an interview on 7/27/22 at 3:16 p.m., LPN 1 indicated there definitely were maggots in the wounds. She had seen approximately four of them on both legs when she unwrapped the dressings and after spraying the cleanser on the wounds. She notified the DON and the Physician. The Physician ordered an antibiotic. The legs were then cleansed and left open to the air. She had spoke with the family, though had not informed them about the maggots in the wounds. She had not used the hydrogen peroxide on the wounds. This Residential tag relates to Complaint IN00386025.			
R 0087 Bldg. 00	410 IAC 16.2-5-1.3(b)(1-3) Administration and Management - Noncompliance (b) The licensee shall provide the number of staff as required to carry out all the functions of the facility, including the following: (1) Initial orientation of all employees. (2) A continuing inservice education and training program for all employees. (3) Provision of supervision for all employees. Based on record review and interview, the Administrator failed to ensure adequate provision of medical care was provided to a resident, related to a resident with a debriding treatment to a wound with slough (stage 3) being completed by	R 0087	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are	08/19/2022

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	a QMA and not a licensed nurse, for 1 of 3 residents reviewed for provision of care. (Resident B) Finding includes: Resident B's record was reviewed on 7/27/22 at 12:27 p.m. The diagnoses included, but were not limited to, dementia. A Physician's Order, dated 6/23/22, indicated Santyl ointment (debriding agent) was to be applied to the bilateral lower extremities' open areas daily. The Medication Administration Record, dated 6/2022, indicated QMA 2 completed the treatment of the Santyl on 6/27/22 and 6/28/22. The Medication Administration Record, dated 7/2022, indicated QMA 2 completed the treatment of Santyl on 7/2/22, 7/3/22, 7/4/22, and 7/8/22. During an interview on 7/27/22 at 3:28 p.m., the Director of Nursing indicated the MARs were initialed that the Santyl treatment had been completed by the QMA. An Assisted Living wound care policy, dated 8/11/16 and received from the Administrator as current, indicated a Nurse would coordinate the overall nursing care of each resident who received applications of dressings. The QMA Basic Curriculum, dated 10/2003, indicated the QMA was prohibited from administering a treatment that involved an advanced skin condition, which included areas staged more than a stage 1 (non-blanchable red intact skin).		accurate, true representation of the quality of care provided, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1)Resident B was discharged from the facility on 7/26/2022 to the hospital and will not be returning to the facility. 2)All other residents residing on the assisted living unit potential to be affected by the same deficient practice. All residents whom have a wound were assessed to ensure proper nursing assessment was completed with treatments. 3)All QMA's and nurse's educated on a QMA's Scope of Practice/Basic Curriculum including that they cannot administer a treatment that involves an advanced skin	

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	This Residential tag relates to Complaint IN00381857.		condition.The ED, DHS or designee will audit five random residents TAR's 5 times weekly for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months to ensure that QMA's are not completing treatments that are outside of their scope of practice. 4)Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5)8/19/2022	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review and interview, the facility failed to ensure a resident who had fallen received necessary services after the fall related to lack of follow up assessments after a fall which resulted in a small head hematoma, for 1 of 3 residents reviewed for falls. (Resident B) Finding includes: A Fall Event, dated 7/20/22 at 10:09 a.m., indicated an unwitnessed fall occurred at 9:30 a.m. There was a hematoma to the right top of the head. A neurology assessment was completed. There were no further assessments completed after the initial assessment. The Fall Event Form	R 0240	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the	08/19/2022

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	indicated there was to be four follow-up assessments after a fall. During an interview on 7/27/22 at 3:28 p.m., the Administrator indicated the nurses were to document all follow up assessments after a fall and there were no follow up assessments noted after the initial assessment. A facility Policy for guidelines for the electronic medical record, dated 8/11/16, indicated 72 hour follow up reviews would be completed after an event. This Residential tag relates to Complaints IN00381857 and IN00386025.		requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1)Resident B was discharged from the facility on 7/26/2022 to the hospital and will not be returning to the facility. 2)All other residents whom are a fall risk have the potential to be affected by the same deficient practice. An audit of the last 14 days of falls was completed to ensure that neurological checks were completed and appropriate response to be completed if not. 3)All nurse's were educated on the Assisted Living fall policy including ensuring that follow up neurology checks are completed at least 72 hours post fall. The DHS or designee will audit all fall events 5 times weekly for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months to ensure that appropriate assessments are being completed for 72 hours after resident falls. 4)Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly	

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			QAPI meeting as facilitated by the Executive Director; audits will be discontinued after 6 months if no further concerns are identified. 5)8/19/2022	