		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/29/2022			
	ROVIDER OR SUPPLIE		814 S 6	STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI				
	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
TAG F 0000 Bldg. 00	This visit was for thome Complaint I and Residential Coincluded the Invest Complaint IN0038 Complaint IN0038 Federal/state deficiallegations are cite Complaint IN0038 Federal/state deficiallegations are cite F840, F842, R0087 Complaint IN0038 deficiencies related R0002, R0036, R0 Unrelated deficience	the Investigation of Nursing No0381754 and Nursing Home omplaint IN00381857. This visit digation of Residential 6025.  1754 - Substantiated. dencies related to the dat F840.  1857 - Substantiated. dencies related to the dat F677, F684, F759, F770, 7 and R0240.  6025 - Substantiated. State dat to the allegations are cited at 052, and R0240.  cies are cited.  27, 28, and 29, 2022	F 0000	CROSS-REFERENCED TO THE APPROPRI	DATE DATE			
	Census Payor Type Medicare: 16 Medicaid: 30 Other: 10	s:						

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

(X6) DATE

TITLE

Any defiency statement 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 disclodays 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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ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  07/29/2022	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		814 S 6	ADDRESS, CITY, STATE, ZIP COD STH ST CELLO, IN 47960			
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
SS=D	These deficiencies accordance with 4  Quality review cord  483.24(a)(2)  ADL Care Provid §483.24(a)(2) A rearry out activitie necessary service nutrition, groomin hygiene;  Based on observation interview, the facility who required exterreceived incontines of 3 residents review (Residents G, F, and Findings include:  1. The following of 7/28/22:  At 8:31 a.m., he was a faint urine service outside of the room. At 8:59 a.m., CNA CNA 3 indicated the room. She indicated the room. She indicated the room of the room of the room of the room of the room. She indicated the room of the	ed for Dependent Residents resident who is unable to s of daily living receives the es to maintain good and, and personal and oral iton, record review, and lity failed to ensure residents ansive to dependent care and care in a timely manner, for 3 ewed for incontinent care. The care in a timely manner in a timely manner in a living to dependent care. The care in a timely manner in a living to a livi	F 0677	The submission of this plan of correction does not indicate ar admission by White Oak Healt Campus that the findings and allegations contained herein a accurate, true representation of the quality of care provided, ar living environment provided to residents of White Oak Health Campus. The facility recognize its obligation to provide legally medically necessary care and services o its residents in an economic and efficient manne. The facility hereby maintains it in substantial compliance with requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with a state and federal requirements governing the management of facility. It is thus submitted as	n th re of nd the es and r. t is the or or o defined this states this states the second of the secon	

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a large amount of wetness in the incontinent brief

observed. CNA 4 indicated he was probably last

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matter of statute only. The facility

respectfully requests from the

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CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPI	ETED	
		155782	B. WING			07/29	/2022	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					TH ST			
WHITE	DAK HEALTH CAM	PUS	M	ONTI	CELLO, IN 47960			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	l II	)			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	,	R LSC IDENTIFYING INFORMATION		AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
1710		nence around 4 or 5 a.m. and	11	10	department a desk review for		DITTE	
		ecked since the beginning of						
					substantial compliance.			
		The bowel movement on the			1)Residents G, F and L were			
		vetness on the bottoms sheet			placed on a toileting schedule			
		dle back to the middle thigh.			before meals, after meals and			
		ess or excoriation to the			before bed where they are laid			
		tinent care was completed and			down and checked at minimul			
	the bottom sheet w	as changed.			every two hours. Residents F	and		
					L were assessed by the facilit	y		
	Resident G's record	d was reviewed on 7/28/22 at			wound nurse immediately and	l		
	9:10 a.m. The diag	noses included, but were not			physician notified for appropri	ate		
	limited to, cerebral ischemia and adult failure to				treatment orders as well as th	е		
	thrive.				residents responsible party wa	as		
					notified. The skin concerns			
	A Quarterly Minim	num Data Set (MDS)			identified on Resident F and L			
		7/6/22, indicated a severely			have since been healed.	-		
		status, required extensive			2)All incontinent residents have	<b>1</b> 0		
		or bed mobility, transfers, and			the potential to be affected. A			
		always incontinent of bowel			•	SKIII		
	and bladder.	ilways incomment of bower			assessment of all incontinent			
	and bladder.				residents was completed on the			
		1/05/00 : 1: . 1 : .			date of incident and no new sl			
		1/27/22, indicated moisture			areas were identified. C.N.A.'s	•		
	_	e to the buttock. The			4 and 5 were individually educ			
	interventions include	ded to keep clean and dry.			on the date of incident on prop			
					incontinence, peri care and sk	in		
	A Care Plan, dated	4/12/22, indicated an			integrity.			
	F	tional status in regards to bed			3)All nursing staff in-serviced	by		
		toileting, and eating. The			the ED and DHS on ADL care	for		
	interventions include	ded extensive assistance was			dependent residents including	l		
	needed for toileting	5.			incontinence and peri-care po	licy.		
					The ED, DHS or designee will	-		
	A Care Plan, dated	10/6/21, indicated there were			complete rounds of five incon-			
		nence. The interventions			residents a week for 4 weeks,			
	•	was needed for toileting as			times a week for 4 weeks, we			
		nent care as needed.			for 4 weeks and then monthly	-		
					months to ensure that approp			
	2 The following w	vas observed for Resident F on			incontinence care is being			
	7/28/22:	vas observed for resident i on			provided.			
	1120122.					nio		
1	1				4) Ongoing compliance with the	IIS	I	

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At 9:47 a.m., Resident F was sitting in a Broda

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corrective action plan will occur as

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155782		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/29/2022	
	PROVIDER OR SUPPLIED DAK HEALTH CAM			814 S 6	DDRESS, CITY, STATE, ZIP COD TH ST CELLO, IN 47960		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	(X5) COMPLETION
TAG	(high back reclining in the lounge.  At 12 p.m., she was the Broda chair.	R LSC IDENTIFYING INFORMATION g chair) chair in front of the TV s in the Dining Room sitting in vas in the lounge sitting in the Nurses' Station.		TAG	the DHS and/or designee will present the audits at the monti QAPI meeting as facilitated by Executive Director; audits will discontinued after 6 months if further concerns are identified. 5) 8/19/2022	the be no	DATE
	resident to her room to the bed. CNA 3 in checked and incont around 7 -7:30 a.m bed. CNA 5 indicate checked for inconti breakfast, and befo activities this morn checked. The income was a pin point ope buttock. Incontinent	3 and CNA 5 assisted the and transferred her manually indicated the resident had been inent care had been given when she was assisted out of red residents were usually mency in the morning, after re lunch. She had been in ing so she had not been intinent brief was wet. There in area observed to the right it care was completed. No used. A new incontinent brief					
		was reviewed on 7/28/22 at noses included, but were not ad dementia.					
	indicated a short an required extensive	assessment, dated 7/8/22, d long term memory problem, assistance of two for transfers, bileting, and was always el and bladder.					
	assistance with toil	7/12/22, indicated nterventions included eting would be offered and ould be completed as needed.					
	An interview on wi	th the Administrator on 7/28/22					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155782		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/29/2022	
	PROVIDER OR SUPPLIER			814 S 6	.DDRESS, CITY, STATE, ZIP COD TH ST CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	reading activity fro received an one on the Nurses' Station	ted the resident was in a group m 8:15 a.m. to 8:30 a.m. and one activity in the lounge by 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.						
	CNA 3 and CNA 5 wheelchair to the bilift. The incontinen CNA 3 indicated th was around 8:30 a.r. completed. There w	vation on 7/28/22 at 1:33 p.m., assisted Resident L from the ed with the use of a mechanical t brief was saturated with urine. He last check for incontinence m. Incontinent care was vas a small open area observed and the right buttock had an k.					
	12:50 p.m. The diag	was reviewed on 7/29/22 at gnoses included, but were not mellitus and dementia.					
	indicated a severely Required extensive mobility, transfers,	assessment, dated 5/27/22, impaired cognitive status. assistance of two staff for bed and toileting, was frequently els and always incontinent of					
	6/8/22, indicated ep	11/25/20 and reviewed on pisodes of incontinence. The ded offers and assistance with provided as needed.					
	6/8/22, indicated a interventions include	11/25/20 and reviewed on risk for skin breakdown. The ded to keep clean as possible exposure to moisture.					

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ENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED		
		155782	B. WING		07/29/2022		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  NOY MUST BE PRECEDED BY FULL  DESCRIPTION OF THE OPERATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			
PREFIX TAG	The Administrator observation on 7/25  This Federal tag refactor of 3.1-38(a)(3)  483.25  Quality of Care § 483.25 Quality of care is applies to all treat facility residents. comprehensive a facility must ensu treatment and car professional standar comprehensive pand the residents Based on observati interview, the facil and care was proviprofessional standar treatments of medic without a Physician without a Physician the areas not comp	r LSC IDENTIFYING INFORMATION was informed of the 8/22 at 5:38 p.m.  lates to Complaint IN00381857.  of care a fundamental principle that the the theoretical content and care provided to Based on the seessment of a resident, the re that residents receive re in accordance with dards of practice, the erson-centered care plan,	F 0684	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	08/19/2022		
	Findings include:	,		Campus. The facility recognize its obligation to provide legally medically necessary care and			
	6 indicated Resider negative pressure v runs for seven days site located on the PICO had stopped applying Santyl (do	iew on 7/28/22 at 11:25 a.m., RN at K had a PICO (single use wound therapy system that and shuts off) on the surgical buttocks. She indicated the running and they were ebridement agent) to the area bund with gauze. She indicated		services o its residents in an economic and efficient manner. The facility hereby maintains it in substantial compliance with requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible	is the or		

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there was no Physician's Order for this treatment.

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allegation of compliance with all

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 07/29/2022 155782 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 814 S 6TH ST WHITE OAK HEALTH CAMPUS MONTICELLO, IN 47960 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE They had been using this treatment prior to PICO state and federal requirements usage. She indicated the Wound Nurses thought governing the management of this this would be the best treatment until another facility. It is thus submitted as a PICO could be obtained. She indicated the PICO matter of statute only. The facility had been off for a few days. respectfully requests from the department a desk review for During an observation on 7/28/22 at 11:41 a.m., substantial compliance. there was no dressing on the upper buttock 1)Resident K had no adverse wound. RN 6 indicated the dressing had come off. effects as a result of the deficient She indicated the wound had slough and there practice. Resident's physician was an infection in the wound. She then cleaned was notified, and appropriate the wound with normal saline, placed Santyl in the treatment orders were obtained, wound and indicated a nickel thick amount was to no worsening of the wound was be applied. She then packed the wound with noted. Resident E had no adverse gauze and placed a foam dressing over the area. effects as a result of the deficient She then indicated she was going to look to see if practice. Resident's skin tear was there was another PICO in the building that could assessed on 7/28/2022 and wound was healed, appropriate documentation in place. A Physician's Order, dated 7/23/22, indicated the 2)All other residents that have skin Santyl had been discontinued. tears/lacerations have the potential to be affected by the A Physician's Order, dated 7/26/22 as a one time same deficient practice. An audit order, indicated the PICO dressing was to be of all other residents that have changed and the PICO would shut down either current skin tears and/or physician 7/26/22 or 7/27/22 automatically. orders for skin treatments was completed to ensure that an order The Medication Administration Record, dated for the correct treatment is in 7/2022, indicated the PICO was removed on the 6 place and that they have been p.m. to 6 a.m. shift due to urine and was not on assessed weekly. during the 6 p.m. to 6 a.m. shift on 7/27/22 due to 3)All nursing staff educated on there was no PICO, foam dressing or packing 8/19/2022 on ensuring that available. treatment orders are in place for all resident wound treatments, A Physician's order for a treatment due to the ensuring that the physician has PICO not being on was not obtained until 7/28/22 given orders on appropriate at 9:38 p.m. and indicated to loosely pack the area treatment in the event that the with collagen and cover with a dressing every PICO is removed and unable to be four days. put back on, ensuring that the physician is notified of any

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155782	B. W	ING		07/29/	2022
				CEDEET	ADDRESS OF A STATE OF COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
\\		2110		814 S 6			
WHITE	OAK HEALTH CAME	208		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	There was no docur	mentation in the Nurses'			changes in wounds/concerns	with	
	Progress Notes that	indicated when the PICO was			treatments, ensuring that the		
	discontinued and what treatment was in place				physician is notified and		
	when the PICO was no longer used.				documentation is in place whe	n a	
					treatment is changed, the facil		
	During an interview on 7/29/22 at 2:30 p.m., the				policy for skin tear assessmen	-	
	_	(DON) indicated there was no			guidelines that includes ensuri		
	documentation on what the facility had done or				that physician notification and	-	
	when the PICO was discontinued. The Corporate				treatment orders are obtained	for	
	RN indicated on 7/2	26/22 the area was packed			all skin tears as well as that th	ey	
	loosely with Actico	at (antimicrobial dressing).			are assessed at minimum of o	ne	
	The area was to be re-assessed so a decision				time a week per the policy. Th	е	
	could be made if the PICO needed to be replaced.				DHS or designee will complete	)	
					audits to ensure that all skin		
	During an interview on 7/29/22 at 2:51 p.m., LPN 7				concerns have orders and all s	skin	
	indicated another m	urse had packed the wound			concerns are assessed at leas	t	
	and applied a foam	dressing. She was unsure what			weekly in addition to observati	ons	
	it was packed with.	She indicated she packed the			to ensure that the treatments t	hat	
	wound with normal	saline gauze. There had not			are being performed align with	the	
		nother treatment, so she			current physician order a minir	num	
	applied whatever di	ressing was used before. She			of 5 times weekly for 4 weeks	, 3	
	thought the other nu	arse had notified the			times a week for 4 weeks, wee	ekly	
	Physician. There ha	nd not been an order for a			for 4 weeks and then monthly	for 3	
	treatment to the wo	und after the PICO was			months.		
	discontinued.				4) Ongoing compliance with th	is	
					corrective action plan will occu	ır as	
	_	vation on 7/28/22 at 4:14 p.m.,			the DHS and/or designee will		
		ressing on the back of his left			present the audits at the mont	-	
		. He indicated the dressing was			QAPI meeting as facilitated by		
	changed daily.				Executive Director; audits will		
					discontinued after 6 months if		
		was reviewed on 7/28/22 at			further concerns are identified		
		noses included, but were not			5) 8/19/2022		
	limited to, stroke.						
		ted 7/15/22 at 7:06 p.m., indicate					
		ck of the left hand due to a fall.					
		vas applied. The area					
	-	y 1.5 cm, was shallow with a					
	moderate amount of	f blood. The skin tear had					

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	OF CORRECTION	IDENTIFICATION NUMBER  155782	A. BUILDING B. WING	00	COMPL 07/29	ETED
	PROVIDER OR SUPPLIER		814 S 6	ADDRESS, CITY, STATE, ZIP COD 6TH ST CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
F 0686 SS=D	for the skin tear or v changed. There was skin tear.  During an interview Director of Nursing Physician's Order for change the dressing assessments of the swas first found.  A facility policy for guidelines, dated 5/3 Director of Nursing follow-up assessment the skin tear is resol healing.  This Federal tag related 3.1-37  483.25(b)(1)(i)(ii) Treatment/Svcs to	cian's Orders for a treatment when the dressing should be so no further assessment of the or on 7/28/22 at 4:17 p.m., the indicated there was no or the dressing and when to the dressing and the dre				
Bldg. 00	a resident, the faci (i) A resident recei professional stand pressure ulcers an pressure ulcers un condition demonst unavoidable; and (ii) A resident with					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155782	B. W	NG		07/29/	2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8		814 S 6			
WHITE C	OAK HEALTH CAME	DITE			CELLO, IN 47960		
WHITE	PAR HEALTH CAIVIE	-03		WONT	CELLO, IN 47900		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	standards of practice, to					
	l .	prevent infection and prevent					
	new ulcers from d						
	Based on observation, record review, and		F 06	686	The submission of this plan of		08/19/2022
	interview, the facility failed to ensure care was				correction does not indicate ar	า	
	_	n preventions of pressure			admission by White Oak Healt	th	
	ulcers, related to inc				Campus that the findings and		
	*	of 2 residents reviewed for			allegations contained herein a		
	pressure ulcers. (Re	esidents F and L)			accurate, true representation of		
					the quality of care provided, a		
	Finding includes:				living environment provided to		
					residents of White Oak Health		
	1. Resident F was observed on 7/28/22 sitting in a				Campus. The facility recognize		
		ecliner) chair from 9:47 a.m.			its obligation to provide legally	and	
	through 1:47 p.m.				medically necessary care and		
					services o its residents in an		
		3 and CNA 5 assisted the			economic and efficient manne		
		n and transferred her manually			The facility hereby maintains it		
		ndicated the resident had been			in substantial compliance with		
		inent care had been given			requirements of participation for		
		when she was assisted out of			skilled health care facilities. To		
		ed residents were usually			this end, the plan of correction	l	
		nency in the morning, after			shall serve as the credible		
	· ·	re lunch. She had been in			allegation of compliance with a		
		ing so she had not been			state and federal requirements		
		ntinent brief was wet. There			governing the management of		
		n area observed to the right			facility. It is thus submitted as		
	buttock. Incontinen	t care was completed.			matter of statute only. The fac	IIIty	
	D: d 4 El d	was reviewed on 7/28/22 at			respectfully requests from the		
		noses included, but were not			department a desk review for		
	limited to, stroke an				substantial compliance.		
	illilited to, stroke an	id dementia.			1)Decidents F and L were		
	A Quarterly MDC	assessment, dated 7/8/22,			1)Residents F and L were	ı	
					assessed by the facility wound		
	indicated a short and long term memory problem, required extensive assistance of two for transfers,				nurse immediately and physician		
		pileting, was always			notified for appropriate treatme orders as well as the residents		
	I	el and bladder, and had no					
	pressure ulcers.	and bradder, and flad fib			responsible party was notified skin concerns identified on	. 111 <del>C</del>	
	pressure dicers.				Resident F and I have since h	neen	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155782	B. W	ING		07/29/	2022
				CTREET	ADDRESS OF A STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
\\/ UTE		2110		814 S 6			
WHILE	OAK HEALTH CAME	308		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A Care Plan, dated	7/12/22, indicated a risk for			healed.		
	skin breakdown. The interventions included,				2)All incontinent residents are	at	
	assistance in reposit	tioning would be provided as			risk for potential skin impairme	ent	
	needed, she would l	be kept dry and clean, risk for			and to be affected. A skin		
	moisture would be a	minimized on the skin and a			assessment of all incontinent		
	barrier cream would	d be used as needed.			residents was completed on th	ie	
					date of incident and no new sk	in	
	An Event Form, dated 7/28/22 at 2:26 p.m.,				areas were identified. Skin		
	indicated there was an open area to the upper				assessments of fifteen residen	ıts	
	right coccyx area. It	t was round, red, and had scant			will be completed monthly for s	six	
	serosanguinous drai	inage. The area measured 0.1			months, and appropriate action	n	
	centimeters (cm) by 0.1 cm with a depth of less				taken if needed.		
	than 0.1 cm.				3)All nursing staff in-serviced b	ру	
					the ED and DHS on incontiner	nce	
	A Wound Assessment Progress Note, dated				care, maintaining resident skin	1	
	7/29/22 at 11:04 a.r	n., indicated the wound			integrity and repositioning. All		
	presented as moistu	re associated skin damage.			nursing staff in-serviced on		
	The Physician and I	Representative were notified			incontinence care, use of barri	er	
	and an order for ski	n barrier cream twice a day was			cream, turning/repositioning ar	nd	
	received.				noting compromised skin area	s to	
					the nurse immediately. The Nu	ırse	
	1	vation on 7/28/22 at 1:33 p.m.,			Managers will complete skin		
		assisted Resident L from the			assessments of all incontinent		
		ed with the use of a mechanical			residents monthly for six month	hs.	
		t brief was saturated with urine.			The ED, DHS or designee will		
		e last check for incontinence			complete rounds on ten		
		n. Incontinent care was			incontinent residents a week for		
	_	as a small open area observed			weeks, ten incontinent residen		
	_	and the right buttock had an			every other week for 4 weeks,		
	area which was pinl	k.			residents a month for 4 months	s to	
					ensure that appropriate		
		was reviewed on 7/29/22 at			incontinence care is being		
		gnoses included, but were not			provided and turning/reposition	ning	
	limited to, diabetes	mellitus and dementia.			has occurred.		
					4)Ongoing compliance with thi		
		sssessment, dated 5/27/22,			corrective action plan will occu	ır as	
	-	impaired cognitive status.			the DHS and/or designee will		
	_	assistance of two staff for bed			present the audits at the montl	-	
	I -	and toileting, was frequently			QAPI meeting as facilitated by		
	incontinent of bowe	els, always incontinent of	1		Executive Director; audits will	be	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155782	B. W	NG		07/29/	2022
Manage of t	DOLUDED OD CLIDA		_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER			814 S 6	TH ST		
WHITE C	OAK HEALTH CAME	PUS		MONTI	CELLO, IN 47960		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	bladder, and no pres	ssure dicers.			discontinued after 6 months if further concerns are identified.		
	A Care Plan, dated	11/25/20 and reviewed on			5) 8/19/2022		
	6/8/22, indicated a risk for skin breakdown due to incontinency. The approaches included, moisture			1,5,1,1,1,1			
	-	needed, assist to reposition,					
	-	dry, and minimize skin					
	exposure to moistur						
		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.,						
		l was assessed on the buttock					
		pisture associated skin					
		ntinence. Skin barrier cream					
	was ordered twice a	day.					
	A facility policy for	pressure prevention, dated					
	12/1/21, and receive	ed from the Corporate RN as					
	current, indicated th	e skin was to be kept clean,					
	dry and free of body	wastes.					
	3.1-40(1)						
F 0689	483.25(d)(1)(2)						
SS=D	Free of Accident						
Bldg. 00	Hazards/Supervisi	ion/Devices					
3	§483.25(d) Accide						
	The facility must e						
		resident environment					
	_ ,,,,	accident hazards as is					
	possible; and						
	8/83 25/d\/2\Ead	n resident receives					
	_ ,,,,	sion and assistance devices					
	to prevent accider						

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Event ID: 176G11 Facility ID: 012355

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155782	B. W	NG		07/29	/2022
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R		814 S 6			
WHITE C	OAK HEALTH CAM	PUS		MONTICELLO, IN 47960			
	Г				I		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		ion, record review, and	F 00	589	The submission of this plan of		08/19/2022
		ity failed to ensure a resident			correction does not indicate a		
		istive devices to decrease her			admission by White Oak Heal		
		s, related to a resident who was			Campus that the findings and		
	care planned for a mechanical lift transfer being				allegations contained herein a		
	transferred manually, for 1 of 2 residents observed				accurate, true representation		
	for transfers. (Resident F)				the quality of care provided, a		
	Finding includes:  During an observation on 7/28/22 at 1:47 p.m., CNA 3 and CNA 5 transferred Resident F from the				living environment provided to		
					residents of White Oak Health		
					Campus. The facility recogniz		
					its obligation to provide legally	•	
					medically necessary care and	1	
	Broda chair (high back reclining chair) to the bed.  They each placed an arm under the resident's				services o its residents in an economic and efficient manne		
		and used the back of the					
		assist her to a standing			The facility hereby maintains		
	_	ted her to the bed and assisted			in substantial compliance with		
	her into a lying pos				requirements of participation skilled health care facilities. T		
	l liei ilito a lyllig pos	Studii.					
	A Care Plan dated	6/14/21, indicated a risk for			this end, the plan of correction shall serve as the credible	11	
		ical lift could be used for			allegation of compliance with	all	
	transfers.	ical integral of asea for			state and federal requirement		
	Landio.				governing the management o		
	The CNA Profile (	Care Guide, dated 3/23/22,			facility. It is thus submitted as		
		dependent for transfers and a			matter of statute only. The fac		
		s to be used for transfers.			respectfully requests from the	•	
					department a desk review for		
	During an interview	w on 7/28/22 at 5:22 p.m., the			substantial compliance.		
		cated the CNA's should use the					
	_	ident care and acknowledged a			1)Resident F was assessed b	oy a	
		ould have been used for the			licensed nurse and no skin	,	
	transfer.				concerns or adverse effects fi	rom	
					transferring her with two peop		
	3.1-45(2)				was noted. The physician was		
					notified of resident's order that		
					may be transferred with a		
					mechanical lift or via two staff	F	
					members; order was clarified	that	
					resident should be transferred		
					two staff members via a gaitb	elt	

PRINTED: 08/26/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155782	A. BUILDING B. WING	00	COMPLETED 07/29/2022
	ROVIDER OR SUPPLIER		814 S 6	ADDRESS, CITY, STATE, ZIP COD STH ST CELLO, IN 47960	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				and may transfer using a mechanical lift was discontinu 2)All other residents that are transferred with a mechanical have the potential to be affect. All review of each resident's physician orders was completed to ensure that the resident car guide reflects that they are a mechanical lift as well as their plan of care. A skin assessme on each resident that is ordered the use of a mechanical lift has been completed.  3)All nursing staff educated or 8/19/2022 on following physicial orders/careguides for resident transfers as well as on the Gas Belt policy. Each resident roor appropriate residents has been stocked with a gait belt. All nursing staff educated on follous physician orders for resident transfers and following resident careguides for transfers. The DHS or designee will complete observations of transfers to enthat the physician order is followed: five residents a weel 4 weeks, five residents a weel 4 weeks, five residents every week for 4 weeks and five residents a month for 4 month ensure that appropriate residents a month for 4 month ensure that appropriate residents are being provided.  4)Ongoing compliance with the corrective action plan will occur the DHS and/or designee will present the audits at the mont QAPI meeting as facilitated by Executive Director; audits will present the audits at the monton that the physician order is a distant to the physician order and the monton that the physician order is a distant to the physician order and the physician order and the physician order is followed:	lift ed. ed ee ent ed s n ian it m for n owing e nsure k for other s to ent is ur as hly v the

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED 07/29/2022	
		155782	B. WING			
	PROVIDER OR SUPPLIER		814 S 6	ADDRESS, CITY, STATE, ZIP COD 6TH ST ICELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication §483.45(f) Medica	n Error Rts 5 Prcnt or More ation Errors.		discontinued after 6 months if further concerns are identified 5)8/19/2022		
	percent or greater Based on observation interview, the facility error rate of less that observed during 4 r 3 errors in medication opportunities for er administration. This rate of 11.53. (Resingular opportunities)  1. RN 6 was observed as preparing Resingular opportunities 1. RN 6 was observed opportunities 1. RN 6 was observed opportunities She placed the follow plastic medication of aspirin 81 mg (mill B12, one tablet cranberry 450 mg, of donepezil (cognitive tablets) ferrous sulfate (iror levothyroxine (thyr loratadine (allergy))	dication error rates are not 5 ; con, record review, and ty failed to ensure a medication an 5% for 3 of 5 residents medication pass observations. cons were observed during 26 rors in medication as resulted in a medication error dents N, O, & P)  eved on 7/28/22 at 8:10 a.m. She dent N's morning medications. owing medications in the cup: igrams), 1 tablet cone tablet eve enhancer) 5 mg, two half an), 325 mg, one tablet oid) 50 micrograms, one tablet	F 0759	The submission of this plan of correction does not indicate a admission by White Oak Heal Campus that the findings and allegations contained herein a accurate, true representation the quality of care provided, a living environment provided to residents of White Oak Health Campus. The facility recognizits obligation to provide legally medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains in substantial compliance with requirements of participation of skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with state and federal requirement governing the management of facility. It is thus submitted as	n th th are of and o the o the or ses of and o the or ses of and of the or ses of and of the or ses of and of the or ses of the	
	_	equivalent, one tablet essant), 50 mg, one tablet		matter of statute only. The factor respectfully requests from the department a desk review for	-	

vitamin C 250 mg, one tablet.

substantial compliance.

1)Resident N, O, and P were

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155782	B. WI	NG		07/29/2022	
NAME OF I	PROVIDER OR SUPPLIEF	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
\TE 6		7110		814 S 6			
WHITE OAK HEALTH CAMPUS			MONTI	CELLO, IN 47960			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	, L	DATE
	She indicated there	were 12 tablets in the cup,			observed for 72 hours post me	ed	
	then proceeded into	the resident's room and			pass and had no negative affe	cts	
	administered the me	edications.			r/t the deficient practice.		
					2)All residents that reside in th	ie	
	The resident reques	ted a pain medication at that			facility and have physician ord	ers	
	time, the pain was a	assessed, and then a			for medications to be administ	ered	
	hydrocodone (pain)	7-325 mg tablet was given.			by the facility staff have the		
					potential to be affected by the		
	Resident N's record	was reviewed on 7/29/22 at 10			deficient practice. Medication		
	a.m. A Physician's Order, dated 6/10/22, indicated				pass audits will be completed	by	
	losartan 25 mg tablets, administer 1 1/2 tablets				the DHS and/or designee and		
	daily between 6 a.m. and 10 a.m.				individual education will be		
					completed as needed.		
	The losartan had not been administered.				3)All Nurse's educated on		
					following physician orders for		
	2. During an obser	vation on 7/28/22 at 11:02 a.m.,			medication pass, ensuring tha	t the	
	RN 6 prepared Resi	ident O's intravenous (IV) of	5 Rights of Nursing Administration				
	cefepime (antibiotic	c) 1 gm (gram). The cefepime			are followed, clarifying physici	an	
	was mixed with 50	milliliters (ml) of 0.9% normal			orders for pharmacy interchan	ges	
	saline.				as well as the medication		
					administration time policy. The	)	
		der, reviewed at the time of the			ED, DHS or designee will		
		repared, indicated the cefepime			complete medication		
		th 50 ml. of dextrose. RN 6			administration observations fo	r ten	
	_	nacy recommended normal			residents every week for 4 we	eks,	
		ne infusion and had not			ten residents every other weel	k for	
		ne Physician as of that time.			4 weeks and then ten resident	S	
		al saline had been used for the			weekly for 4 months and prese	ent	
		nedication was ordered on			any concerns at the monthly C	(API	
	7/18/22.				meeting.		
					4)Ongoing compliance with thi		
	1 -	der, dated 7/18/22, indicated			corrective action plan will occu	ır as	
	_	be mixed with 50 ml of			the DHS and/or designee will		
	dextrose and was to	be administered twice a day.			present the audits at the mont	-	
					QAPI meeting as facilitated by		
	_	tion pass observation on			Executive Director; audits will		
		n., the Corporate Regional RN			discontinued after 6 months if		
		g of Victoza (antidiabetic)			further concerns are identified	-	
	subcutaneous via po	en to Resident P.			5)8/19/2022		
	ĺ		1				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 07/29/2022	
	PROVIDER OR SUPPLIER		814 S	ADDRESS, CITY, STATE, ZIP COD 6TH ST ICELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE	
F 0770 SS=D Bldg. 00	11:15 a.m. The Phy indicated 1.8 mg wadaily, between 6 a.r.  A Medication Adm 11/2018 and receive current, indicated, the administration were included, right drug Medications were the accordance with the prescriber.  This Federal tag rel 3.1-25(b)(9) 3.1-48(c)(1)  483.50(a)(1)(i) Laboratory Service §483.50(a) (a) Laboratory Service §483.50(a)(1) The obtain laboratory sof its residents. The quality and time (i) If the facility proservices, the service specified in part 4. Based on record reverse failed to ensure a relaboratory service retest not completed a reviewed for laboratory service of the facility of the facility proservice of the service of the servic	inistration policy, dated and from the Administrator as the five rights of medication to be followed, the five rights, right dose, and right time. To be administered in a written orders of the attest to Complaint IN00381857.  The action of the services of the services to meet the needs are facility must provide or services to meet the needs are facility is responsible for seliness of the services. The services wides its own laboratory of the services must meet the ments for laboratories	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 ar accurate, true representation o the quality of care provided, an living environment provided to residents of White Oak Health Campus. The facility recognize	e f d the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155782	B. WING 07/29/2022			2022	
			<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L.					
WHITE C	OAK HEALTH CAME	ou e	814 S 6TH ST MONTICELLO, IN 47960				
WHITE	PAR HEALTH CAIVIE	-03		WONT	CELLO, IN 47900		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	ischemia and adult	failure to thrive.			its obligation to provide legally	and	
					medically necessary care and		
	1	r, dated 6/3/22, indicated a			services o its residents in an		
	complete blood cou	nt (CBC) and a complete			economic and efficient manne	r.	
	metabolic profile (C	CMP) was to be completed on			The facility hereby maintains i	t is	
	6/10/22.				in substantial compliance with	the	
					requirements of participation f	or	
					skilled health care facilities. To	)	
	A Nurse's Progress	Note, dated 6/13/22 at 3:41			this end, the plan of correction	1	
	p.m., indicated the l	aboratory company was			shall serve as the credible		
	unable to obtain the	blood for the CBC and CMP			allegation of compliance with a	all	
on 6/10/22 and on 6/13/22. The laboratory				state and federal requirements	S		
specimen would be attempted on the next				governing the management of	this		
	laboratory draw day	7.			facility. It is thus submitted as	а	
					matter of statute only. The fac	ility	
	There was no docur	nentation that indicated the			respectfully requests from the		
	Physician had been	notified about the test not		department a desk review for			
	completed. There w	as no documentation that			substantial compliance.		
	indicated the test wa	as attempted on the next	1)Resident G had no adverse				
	laboratory draw day	<i>7</i> .	effects from the deficient practice,				
					their labs were drawn on		
	A CBC and CMP w	vas completed on 6/20/22.	6/20/2022 and no concerns noted;				
					resident's physician was notifi		
	_	on 7/28/22 at 2:37 p.m., the			that the labs were completed		
		(DON) indicated the normal			6/20/2022 instead of 6/10/202	2	
		vs are Monday, Wednesday,			and follow up labs completed	with	
	_	icated the laboratory test had			no new concerns.		
	1	on those days. She indicated			2)All other residents that have	!	
	_	lso not been notified the tests			physician orders for laboratory	/	
	were not completed	as ordered.			draws have the potential to be	<b>:</b>	
					affected by the same deficient		
	This Federal tag rel	ates to Complaint IN00381857.			practice. A review of the last		
					days of labs completed to ens	ure	
	3.1-49(c)				completion and appropriate		
					physician notification.		
					3)All nursing staff educated or		
					8/19/2022 on the lab procedur	re ·	
					including notifying the physicia		
					any labs that are not drawn or		
					date of the physician order an	d	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE COMPI 07/29	LETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE PPROPRIATE	(X5) COMPLETION DATE	
				new physician orders to obtained as appropriate or designee will comple laboratory audits to ensure labs are drawn on the oby the physician as well physician notification is timely at a minimum of week for 4 weeks, 3 times for 4 weeks, weekly for and then monthly for 3 and any concerns present the monthly QAPI meet 4)Ongoing compliance corrective action plan with DHS and/or designer present the audits at the QAPI meeting as facilities Executive Director; audits and the present discontinued after 6 monthly for 2 further concerns are identified by 19/2022	e. The DHS ete sure that date ordered I as completed 5 times a nes a week 4 weeks months ented at cing. with this vill occur as ee will e monthly ated by the lits will be onths if no		
F 0840 SS=D Bldg. 00	§483.70(g)(1) If the qualified profession specific service to the facility must have residents by a perfacility under an ansection 1861(w) of described in paragraphs (§483.70(g)(2) Arrasection 1861(w) of the qualified profession 1861(w) of the qu	esources  outside resources. e facility does not employ a nal person to furnish a be provided by the facility, ave that service furnished to son or agency outside the rrangement described in f the Act or an agreement graph (g)(2) of this section.  angements as described in f the Act or agreements ces furnished by outside					

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Event ID:

176G11

Facility ID: 012355

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155782	B. W	ING		07/29/2022	
op 1				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	S.		814 S 6	STH ST		
	OAK HEALTH CAME	PUS	•	MONTI	CELLO, IN 47960		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
		pecify in writing that the					
	facility assumes re						
		ces that meet professional nciples that apply to					
		riding services in such a					
	facility; and	riding services in such a					
	(ii) The timeliness	of the services					
		view and interview, the facility	F 0	840	The submission of this plan of		08/19/2022
		side resources were used as	1.00	J- <b>T</b> U	correction does not indicate a		00/17/2022
		a resident with a consult			admission by White Oak Heal		
	· ·	a Neurosurgeon not provided			Campus that the findings and		
	transportation to the appointment for 1 of 3				allegations contained herein a	re	
	residents reviewed for outside resources visits.				accurate, true representation		
	(Resident E)				the quality of care provided, a		
					living environment provided to		
	Finding includes:				residents of White Oak Health		
					Campus. The facility recognize	es	
	Resident E's record	was reviewed on 7/28/22 at			its obligation to provide legally	and	
	2:04 p.m. The diag	noses included, but were not			medically necessary care and		
	limited to, stroke.				services o its residents in an		
					economic and efficient manne	r.	
	-	r, indicated the resident had a			The facility hereby maintains i		
		t with a Neurosurgeon on			in substantial compliance with		
	7/7/22.				requirements of participation f		
					skilled health care facilities. To		
		nentation to indicate the			this end, the plan of correction	1	
	resident had gone to	the appointment.			shall serve as the credible		
	A NII NI ( 1 )	-16/22/22 -44.19			allegation of compliance with		
		ed 6/23/22 at 4:18 p.m.,			state and federal requirements		
		nt said he would arrange his to the appointment on 7/7/22.			governing the management of		
	own transportation	to the appointment on ////22.			facility. It is thus submitted as		
	There was no follow	w up with the resident to			matter of statute only. The fac respectfully requests from the	-	
		to find his own transportation			department a desk review for		
	to the appointment.	_			substantial compliance.		
	to the appointment.				1)Resident E had no adverse		
	During an interview	on 7/28/22 at 4:17 p.m., the			effects as a result of the defici	ent	
	_	ated she was not sure if he			practice. Resident E's missed		
		ment on 7/7/22. The			appointment was rescheduled		
		en written on the calendar but			8/11/2022 in which resident w		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155782	A. BUILDING B. WING	00	COMPLETED 07/29/2022
		133762	B. WING		0112912022
NAME OF	PROVIDER OR SUPPLIE	ER.		ADDRESS, CITY, STATE, ZIP COD	
\A# UTE /	0.414.115.41.711.0.414	IDUO		6TH ST	
WHILE	OAK HEALTH CAM	IPUS	MONT	ICELLO, IN 47960	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		if he went to the appointment.		to the appointment.	
		d to the Administrator she was		2)All other residents that have	
	unsure if the reside	_		scheduled physician appointr	
		7/22. The resident informed the		have the potential to be affect	
		and not gone to the appointment		by the same deficient practice	Э.
		why he didn't go. No one was		An audit of all residents with	
	1	ot go to the appointment. She		appointments in the last 30 d	-
		vas available for him to take.		will be completed to ensure the	nat
		document when residents left		resident was at appointment,	
		appointments or why they were		documentation in place of	
		pointments. She indicated she		appointment or appointment i	S
	would call the Physician's Office to see if he went to the appointment or not.			rescheduled. An audit of all	4l
	to the appointment	or not.		residents with appointments i	
	Duning on interview	ry on 7/20/22 at 11,22 a m. tha		next 30 days reviewed to ens	
		w on 7/29/22 at 11:22 a.m., the cated she notified the		that transportation is schedule	ea
		and he had not gone to the		and physician order in place.	
		was still unsure why, but		3)Transportation Assistant educated on the transportation	un.
		intment had been rescheduled.		policy. All nursing staff educa	
	indicated the appoi	intificit had been resentedited.		on 8/19/2022 on ensuring that	
	This Federal tag re	elates to Complaints IN00381754		transportation is scheduled for	
	and IN00381857.	rates to Complaints II (0050175)		resident appointments either	
	una ir (00501057.			the facility bus or an outside	und
	3.1-13(m)			resource, ensuring that it is	
				documented in the resident's	chart
				if they go to the appointment	
				well as a reason if they do no	
				to the appointment and if it is	
				rescheduled as appropriate.	All
				resident appointments and	
				transportation arrangements	will
				be put in one calendar book a	and
				kept at a centralized location.	The
				Transportation Assistant and	or
				designee will check the calen	dar
				three times a week to ensure	that
				transportation is scheduled. T	-he
				Executive Director, DHS or	
				designee will complete audits	
				the physician appointments to	)

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/29/2022	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.7 Resident Records §483.20(f)(5) Resi (i) A facility may note in the facility may resident-identifiable accordance with a agent agrees not a information exception in the facility may resident agrees not a secondance with a gent agrees not a secondance with a secon	70(i)(1)-(5) - Identifiable Information dent-identifiable information. of release information that able to the public. If release information that is let o an agent only in contract under which the of use or disclose the to the extent the facility of do so.  I records. I records. I records and practices, the leain medical records on are-			ensure that transportation is scheduled, and documentat has occurred for appointme a minimum of 5 times a week weeks, 3 times a week for 4 weeks, weekly for 4 weeks then monthly for 3 months a any concerns presented at a monthly QAPI meeting.  4)Ongoing compliance with corrective action plan will on the DHS and/or designee were present the audits at the modulation of the CAPI meeting as facilitated executive Director; audits we discontinued after 6 months further concerns are identified by 19/2022	ion ints at ek for 4 and ind the this ccur as ill onthly by the ifl be if no	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  07/29/2022			
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION V organized	ID PREFIX TAG	PROVIDER'S PLAN OF CORR. (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION	ON		
	§483.70(i)(2) The confidential all inforesident's records regardless of the the records, exce (i) To the individual representative who law; (ii) Required by Law; (iii) For treatment, operations, as percompliance with 4 (iv) For public hear abuse, neglect, or oversight activities proceedings, law organ donation pure or to coroners, and to a health or safety as compliance with 4 §483.70(i)(3) The medical record individual re	facility must keep formation contained in the form or storage method of put when release isal, or their resident lere permitted by applicable aw; payment, or health care rmitted by and in 15 CFR 164.506; alth activities, reporting of redomestic violence, health is, judicial and administrative enforcement purposes, research purposes, redical examiners, funeral avert a serious threat to be permitted by and in 15 CFR 164.512.  Ifacility must safeguard formation against loss, authorized use.  Ilical records must be me required by State law; or in the date of discharge requirement in State law; or years after a resident						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155782	B. W	ING		07/29	/2022
NAME OF F	AD CAMPED OF CAMPACIES			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF E	PROVIDER OR SUPPLIEF	· ·		814 S 6	STH ST		
WHITE OAK HEALTH CAMPUS			MONTI	CELLO, IN 47960			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT			(X5)
PREFIX	` `	ICY MUST BE PRECEDED BY FULL				TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` '	resident's assessments;					
	services provided	ensive plan of care and					
	· ·	any preadmission					
		sident review evaluations and					
	_	inducted by the State;					
		urse's, and other licensed					
	professional's pro						
		diology and other diagnostic					
		s required under §483.50.					
		view and interview, the facility	F 08	342	The submission of this plan of		08/19/2022
	failed to ensure the resident's record was accurate				correction does not indicate a	า	
	and complete, related to an anticoagulant				admission by White Oak Healt	:h	
	(warfarin) medication given and not documented				Campus that the findings and		
	as given, for 1 of 11 residents reviewed for medical				allegations contained herein a	re	
	records. (Resident 0	G)			accurate, true representation of		
					the quality of care provided, a		
	Finding includes:				living environment provided to		
	Resident G's record	was reviewed on 7/28/22 at			residents of White Oak Health Campus. The facility recognize		
		noses included, but were not			its obligation to provide legally		
	l -	ischemia and adult failure to			medically necessary care and	and	
	thrive.	100110111111111111111111111111111111111			services o its residents in an		
					economic and efficient manne	r.	
	A Physician's Order	r, dated 6/21/22 to 6/28/22,			The facility hereby maintains i		
	1	arfarin 6 mg (milligrams) on			in substantial compliance with		
	_	on Sunday, Monday,			requirements of participation f		
	Wednesday, Thurso	day, Friday, and Saturday.			skilled health care facilities. To		
					this end, the plan of correction	l	
		ministration Record (MAR),			shall serve as the credible		
	· ·	ated warfarin 6 mg had not			allegation of compliance with	all	
		on $6/21/22$ . The order for the			state and federal requirements		
	warfarin 6 mg was	not on the MAR.			governing the management of		
		<b>5</b> /20/20 12 2 2 5			facility. It is thus submitted as		
	_	v on 7/28/22 at 2:37 p.m., the			matter of statute only. The fac	ility	
	_	indicated the order for the			respectfully requests from the		
		not put in the computer			department a desk review for		
	correctly so it had b	peen left off the MAR.			substantial compliance.		
	Duning a graiteter.				1)Resident G had no adverse		
	During an interview	v on 7/29/22 at 11:24 a.m., the			effects from the deficient pract	ice,	1

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  07/29/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960				
WHITE C (X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				COMPLETION DATE  COMPLE		
				and entering coumadin of correctly into the EMAR. or designee will complete ensure that coumadin or being given as ordered at entered correctly in the laminimum of 5 times with 4 weeks, 3 times a week weeks, weekly for 4 weeks, weekly for 4 weeks, weekly for 3 month 4)Ongoing compliance with a corrective action plan with the DHS and/or designed present the audits at the QAPI meeting as facilitate Executive Director; audit discontinued after 6 more further concerns are identified to the conce	The DHS e audits to reders are and EMAR at reekly for c for 4 eks and hs. vith this Il occur as e will monthly ted by the ts will be oths if no		

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155782		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  07/29/2022		
		100702	В. 111		_	01/23/	
	PROVIDER OR SUPPLIED DAK HEALTH CAM			814 S 6	ADDRESS, CITY, STATE, ZIP COD STH ST CELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	CROSS		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00	Complaint IN00386 Residential Compla	the Investigation of Residential 6025 and Nursing Home and aint IN00381857. This visit igation of Nursing Home 1754.	R 00	000			
		6025 - Substantiated. State I to the allegations are cited at 052, and R0240.					
	Federal/state defici	1857 - Substantiated. encies related to the d at F677, F684, F759, F770, 7 and R0240.					
		1754 - Substantiated. encies related to the d at F840.					
	Survey dates: July	27, 28, and 29, 2022					
	Facility number: 0	12355					
	Residential Census	: 63					
	These State Reside accordance with 41	ntial Findings are cited in 0 IAC 16.2-5.					
	Quality review con	npleted on 8/3/22.					
R 0002 Bldg. 00	(b) A residential c	ntial Care - Offense care facility may not provide ursing care except to the					
		der this rule. view and interview, the facility esident was not provided	R 0	002	The submission of this plan of correction does not indicate a		08/19/2022

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155782		A. BUILDING B. WING	00	COMPLETED 07/29/2022		
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD 6TH ST		
WHITE C	OAK HEALTH CAMP	PUS		ICELLO, IN 47960		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
TAG		sing care, related to wound	IAG	admission by White Oak Heal	5.1.12	
	_	e Assisted Living Memory		Campus that the findings and		
		3 residents reviewed for wound		allegations contained herein a		
	care treatments. (Re			accurate, true representation		
	·			the quality of care provided, a		
	Finding includes:			living environment provided to	the	
				residents of White Oak Health	1	
		was reviewed on 7/27/22 at		Campus. The facility recognize		
		gnoses included, but were not		its obligation to provide legally		
	limited to, dementia	ı.		medically necessary care and	I	
				services o its residents in an		
The Nurses' Progress Notes indicated:				economic and efficient manne		
	On 4/2/22 at 10:49 a.m., the bilateral lower			The facility hereby maintains		
		l, warm, inflamed, and painful.		in substantial compliance with		
	-	xudate present. The Nurse		requirements of participation		
	Physician was faxed	ecting cellulitis" The		skilled health care facilities. T		
	Filysiciali was laxed	i the information.		this end, the plan of correction shall serve as the credible	1	
	On 4/2/22 at 11:45 :	a.m., an order for an antibiotic		allegation of compliance with	الد	
		ceived from the Nurse		state and federal requirement		
	Practitioner.			governing the management o		
				facility. It is thus submitted as		
	On 4/7/22 at 4:47 p.	.m., another order was received		matter of statute only. The fac		
	to continue the antib	piotic for three additional days		respectfully requests from the	-	
	and Tylenol 650 mg	g (milligrams) was to be given		department a desk review for		
	-	omfort. Daily dressing		substantial compliance.		
	-	continued. Yellow exudate		1)Resident B was discharged	from	
		e the lower extremity		the facility on 7/26/2022 to the		
	dressings.			hospital and will not be return	ing	
				to the facility.		
		p.m., the Nurse Practitioner was		2)All other residents receiving	g	
	-	o continued redness, edema		comprehensive care on the		
	and scant drainage. suspected stasis den	The Nurse Practitioner		assisted living unit potential to		
	•	ered bag balm (ointment) to the		affected by the same deficien practice. An audit of all other		
	bilateral lower extre			residents that resident on the		
	onatoral lower extre	mines.				
	On 5/10/22 at 4·04 s	a.m., the bilateral lower		Assisted Living Unit was completed to ensure that		
	extremities were we			comprehensive services were	e not	
		1 &		provided by the Assisted Livir		
			İ	Figure 2, and / toolottod Eivil	.9	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	ľ	JILDING	onstruction 00	(X3) DATE COMPL <b>07/29</b> /	ETED
	PROVIDER OR SUPPLIEF			814 S 6	ADDRESS, CITY, STATE, ZIP COD STH ST CELLO, IN 47960		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
PREFIX TAG	REGULATORY OF On 6/25/22 at 12 p. bilateral lower extry yellow and greenish On 7/16/22 at 12:52 present on the bilatered and warm to totan antibiotic for 10 On 7/16/22 at 8:32 "a little" amount of extremities were cle cleaned, Santyl (del applied to the areas dressed and wrapped On 7/21/22 at 3:41 bilateral lower extremetre to be cleansed (antimicrobial barriand covered with all with roll gauze even On 7/26/22 at 11:23 extremity dressings and yellow drainageresident be transferron On 7/26/22 at 2:04 resident to the hosp The Physician's Ord 4/3/22 to 4/7/22, Barriag twice a day for 4/7/22 to 4/10/22, Eday for five days. 4/13/22 to 4/21/22, extremities twice a 4/21/22 to 6/9/22, but the strength of the strength of the same transferron of the	R LSC IDENTIFYING INFORMATION m., an infection of the of emities continued, there was n exudate on the dressings.  2 p.m., there was green drainage eral lower legs. The areas were uch. An order was received for days.  p.m., the resident complained of pain when the bilateral lower eaned. After the areas were briding agent) ointment was . The lower legs were then od with roll gauze.  p.m., a new treatment for the emities was received. The legs and then acticoat er dressing) was to be applied odominal pads and wrapped ry three days and as needed.  3 a.m., the bilateral lower had a large amount of green e. The family requested the red to the hospital.  p.m., the family transported the ital.  ders were as follows: actrim DS (antibiotic), 800-160 cellulitis. Bactrim DS 800-160 mg twice a bag balm to bilateral lower day until healed. bag balm to bilateral lower		TAG TAG	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 designee will audit any new admissions to the Assisted Living times a week for 4 weeks, we for 4 weeks and then monthly months to ensure that no 4) Ongoing compliance with the corrective action plan will occur the DHS and/or designee will present the audits at the month QAPI meeting as facilitated by Executive Director; audits will discontinued after 6 months if further concerns are identified 5) 8/19/2022	ector  ted  e or ving ss, 3 ekly for 3 his ur as hly v the be no	DATE
		atil healed and as needed.					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPL	
		155782	B. WING	<u> </u>		07/29/	2022
NAME OF F	PROVIDER OR SUPPLIER	-			DDRESS, CITY, STATE, ZIP COD		
				814 S 6			
WHITE	OAK HEALTH CAMI			MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	1	TAG	DEFICIENCI		DATE
		Minerin cream (moisturizing eral lower extremities after the					
	· · · · · · · · · · · · · · · · · · ·	and dried. Then four					
		were to be applied and					
	wrapped with roll g						
		Minerin cream was to be					
	·	to the bilateral lower					
	extremities.						
	6/23/22 to 7/16/22,	Santyl ointment was to be					
	applied to the bilate	ral lower extremity open areas					
	after they were clea	nsed daily.					
	7/16/22 to 7/26/22,	cephalexin (antibiotic) 500 mg					
	three times a day.						
		Santyl ointment was to be					
	applied to the open						
		al lower legs were to be					
		at was to be applied to the					
	open areas every th	ree days.					
	During an interview	on 7/27/22 at 10:30 a.m., the					
		ated the nurses at the facility					
		reatments and was unaware					
	_	rsing Care was not to be					
	completed in the As	ssisted Living areas of the					
	facility by facility s						
	<u></u>	7/07/00 + 2.00	1				
	_	on 7/27/22 at 3:28 p.m., the					
		indicated they had been					
	providing comprehe	ensive care to the resident.	1				
	A facility Assisted	Living wound care policy,					
	l ·	eceived from the Administrator					
		I the resident would be					
	· · · · · · · · · · · · · · · · · · ·	en days to determine if					
		ner appropriate health care was					
	required.	-					
	THE DOMESTIC	1	1				
		g relates to Complaint					
	IN00386025.						

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PRINTED: 08/26/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155782	B. W	ING		07/29/	2022
	PROVIDER OR SUPPLIER			814 S 6	ADDRESS, CITY, STATE, ZIP COD TH ST CELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
PREFIX	(EACH DEFICIEN REGULATORY OR 410 IAC 16.2-5-1.: Residents' Rights-(k) The facility muresident 's physic legal representation noticed: (1) a significant dephysical, mental, of (2) a need to alter is, a need to discontreatment due to a commence a new Based on record reversided to ensure a resident of the ensure a residents reviewed in Representative were changes in condition extremity (BLE) staresidents reviewed in Representative notification.  Finding includes:  Resident B's record 12:27 p.m. The diagolimited to, dementiated to, dementia	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  2(k)(1-2) Deficiency st immediately consult the ian and the resident 's ye when the facility has  celine in the resident 's per psychosocial status; or treatment significantly, that continue an existing form of adverse consequences or to form of treatment. Ye wand interview, the facility resident's Physician and enotified or notified timely of n. related to bilateral lower atus/wounds and falls, for 1 of 3 for Physician and fication. (Resident B)  was reviewed on 7/27/22 at gnoses included, but were not a.  2002 and R0052 for wounds, ovision of care.  Note, dated 5/10/22 at 4:04 BLE were weeping.	R 0	PREFIX TAG	The submission of this plan of correction does not indicate at admission by White Oak Health Campus that the findings and allegations contained herein a accurate, true representation of the quality of care provided, at living environment provided to residents of White Oak Health Campus. The facility recognizatis obligation to provide legally medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains it in substantial compliance with requirements of participation fiskilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with a state and federal requirements governing the management of facility. It is thus submitted as	n the es and r. t is the or or or all s	COMPLETION
	Resident Representa	ss Notes, indicated the ative had not been notified of E and wounds until June 17,			matter of statute only. The fac respectfully requests from the department a desk review for substantial compliance.	-	

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PRINTED: 08/26/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155782		(X2) MULTIPLE ( A. BUILDING B. WING	OO OO	COMP	E SURVEY LETED 0/2022	
NAME OF F	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CO	)D	
				6TH ST		
WHILE	OAK HEALTH CAM		MON	ΓICELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE PPROPRIATE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION	TAG			DATE
	A Namasia Dua anaga	Note data 6/25/22 at 12 m m		1)Resident B was disch	•	
	_	Note, date 6/25/22 at 12 p.m., an infection in the BLE.		the facility on 7/26/2022 hospital and will not be		
		exudate was present.		to the facility.	returning	
	1 chow and green c	Extidute was present.		2)All other residents res	siding on	
	The Nurses' Progre	ss Notes, indicated the		the assisted living unit v	-	
	_	Resident Representative had		any status change have		
	not been notified or	-		potential to be affected		
				same deficient practice.	•	
	A Nurse's Progress	Note, dated 6/26/22, at 1:32		of all residents whom ha		
	p.m., indicated the	necrotic wound bed now had		fall, treatment change o	r status	
	slough.			change in the last 2 wee	eks has	
				been reviewed to ensur	e that	
	The Nurses' Progress Notes indicated the			appropriate notification	has taken	
	_	tative had not been notified of		place.		
	the BLE status.			3)All nurse's will be edu		
				Resident Rights including	-	
		Note, dated 7/21/22 at 3:41		and/or representative n		
	•	ew treatment was ordered for		on status changes, falls		
		as no documentation that		treatments and medicat		
		y had been notified of the		changes. The DHS or d	-	
	treatment change.			will audit all new change		
	A Nurse's Progress	Note, dated 7/21/22 at 10:04		condition, falls, treatme and medication change	_	
	_	resident had chills, the		that family/responsible		
	_	are was 100.4 and oral		notification has occurre	•	
	temperature was 98			weekly for 4 weeks, 3 ti		
	-	Physician and Resident		week for 4 weeks, week		
	Representative was	s notified of the change in		weeks and then monthly	•	
	condition.	<u> </u>		months to ensure that n	-	
				comprehensive care is	being	
	During an interview	w on 7/27/22 at 2:38 p.m., the		provided by an in-house	-	
	_	g (DON) indicated the		4)Ongoing compliance	with this	
	_	been notified on 4/2/22 and		corrective action plan w		
		entation of the Representative		the DHS and/or designed		
	had been notified o	of the status until 7/16/22.		present the audits at the	-	
		- (a- (a- (a- (a- (a- (a- (a- (a- (a- (a		QAPI meeting as facilita	-	
		w on 7/27/22 at 3:05 p.m. the		Executive Director; aud		
	_	rector indicated she was		discontinued after 6 mo		
	unsure who had be	en notified on the BLE status.		further concerns are ide	entified.	

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PRINTED: 08/26/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155782		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/29/2022	
	PROVIDER OR SUPPLIEF		814 S	ADDRESS, CITY, STATE, ZIP COD 6TH ST ICELLO, IN 47960	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	maggots found in the During an interview indicated there defined wounds. She had shad not informed the wounds.  A Fall Event, dated the resident had an had not been notified. A communication produced 8/11/16 and reas current, indicated was to assure adequated to the residents and right to be made awards.	rview indicated there had been he wounds on the BLE.  7 on 7/27/22 at 3:16 p.m., LPN 1 mitely were maggots in the poke with the family, though hem about the maggots in the  7/24/22 at 1:40 a.m., indicated unwitnessed fall. The family had of the fall on 7/24/22.  8 oolicy for Assisted Living, eccived from the Administrator of the purpose of the policy hate information was provided responsible party. They had a vare of changes.		5)8/19/2022	
R 0052 Bldg. 00	(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punis (5) neglect; and (6) involuntary sec Based on record rev failed to ensure a re-	- Offense e the right to be free from: e; hment;	R 0052	The submission of this plan of correction does not indicate a admission by White Oak Heal	n
	wounds to the bilate which the resident l wounds and possible	eral lower extremities (BLE), nad slough present in the e maggots to the wounds. led to ensure the resident was		Campus that the findings and allegations contained herein a accurate, true representation the quality of care provided, a	ure of

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PRINTED: 08/26/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	UILDING	00	COMPL	ETED	
		155782	B. W	ING		07/29/	/2022
NAME OF I	PROVIDER OR SUPPLIER	\$		STREET A	ADDRESS, CITY, STATE, ZIP COD		
WHITE C	OAK HEALTH CAME	PUS		MONTI	CELLO, IN 47960		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION cian or Nurse Practitioner		TAG			DATE
		ne BLE deteriorated. The			living environment provided to residents of White Oak Health		
		ed into the hospital with			Campus. The facility recognize		
		eerations, which had slough			its obligation to provide legally		
		lack and painful. (Resident B)			medically necessary care and		
	present, and were ex	and min punituri (recorded 2)			services o its residents in an		
	Finding includes:				economic and efficient manne	r.	
					The facility hereby maintains i		
	Resident B's record	was reviewed on 7/27/22 at			in substantial compliance with		
	12:27 p.m. The diag	gnoses included, but were not			requirements of participation f		
	limited to, dementia	ı.			skilled health care facilities. To	)	
					this end, the plan of correction	1	
	The Nurses' Progres	ss Notes indicated:			shall serve as the credible		
	On 4/2/22 at 10:49	a.m., the bilateral lower			allegation of compliance with	all	
		d, warm, inflamed, and painful.			state and federal requirements	S	
	-	xudate present. The Nurse			governing the management of		
	_	ecting cellulitis" The			facility. It is thus submitted as		
	Physician was faxed	the information.			matter of statute only. The fac	-	
					respectfully requests from the		
		a.m., an order for an antibiotic			department a desk review for		
	-	ceived from the Nurse			substantial compliance.	_	
	Practitioner.				1)Resident B was discharged		
	On 4/7/22 at 4:47 m	an amothor and an arrag magaired			the facility on 7/26/2022 to the		
		m., another order was received piotic for three additional days			hospital and will not be returni	ng	
		g (milligrams) was to be given			to the facility.  2)All other residents whom ha	VO	
		omfort. Daily dressing			complex wounds on the assist		
		continued. Yellow exudate			living unit have the potential to		
		e lower extremity dressings.			affected by the same deficient		
					practice. An audit of the last 1		
	On 4/13/22 at 8:50	p.m., the Nurse Practitioner was			days of progress notes comple		
		o continued redness, edema			to identify any chronic condition		
		The Nurse Practitioner			whom required immediate		
		matitis on the lower			intervention and/or physician		
	extremities and orde	ered bag balm (ointment) to the			assessment.		
	bilateral lower extre	emities.			3)The DHS and/or designee w	/ill	
					educate all nurse's on providir		
		er assessments completed on			wound assessment prior to		
		the documentation on 5/10/22			obtaining new orders, ensuring	-	
	at 4:04 a.m.				that a physician order is in pla	ce	

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PRINTED: 08/26/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155782			JILDING	00	COMPL 07/29/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	On 5/10/22 at 4:04 a extremities were were the BLE areas until at 12 p.m.  On 6/25/22 at 12 p.m.  There were no furth the BLE areas until  On 7/16/22 at 12:52 present on the bilate red and warm to too an antibiotic for 10  On 7/16/22 at 8:32 pm a little amount of extremities were cle cleaned, Santyl (detapplied to the areas dressed and wrapped There was no assess wounds prior to the On 7/21/22 at 3:41 pm bilateral lower extremities were to be cleaned (antimicrobial barriand covered with alword with roll gauze even There were no furth until 7/26/22 at 11:2	a.m., the bilateral lower seping  er assessments completed on the documentation on 6/25/22  m., an infection of the of emities continued. Tthere was a exudate on the dressings.  er assessments completed on the documentation on 7/16/22.  P.p.m., there was green drainage eral lower legs. The areas were each. An order was received for days.  p.m., the resident complained of pain when the bilateral lower legand. After the areas were oriding agent) ointment was. The lower legs were then d with roll gauze.  sment of the BLE or of Santyl orders initiated.  p.m., a new treatment for the legs and then acticoat er dressing) was to be applied and ominal pads and wrapped by three days and as needed.  er assessments of the BLE 23 a.m. There was no			prior to providing any treatment monitoring of any chronic condition as well as ensuring the physician appointments are made as needed. The DHS or design will review Assisted Living resignurse notes 5 times weekly for weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months to ensure that appropriate action taken.  4) Ongoing compliance with the corrective action plan will occur the DHS and/or designee will present the audits at the month QAPI meeting as facilitated by Executive Director; audits will discontinued after 6 months if further concerns are identified. 5) 8/19/2022	hat ade nee dent 4 d is is is ar as hly the be		
	documentation of the	ne resident having wounds on						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155782		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/29/2022	
	PROVIDER OR SUPPLIEI			814 S 6	DDRESS, CITY, STATE, ZIP COD TH ST CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	the BLE.	CESC IDENTIFTING INFORMATION		TAG			DATE
	extremity dressings and yellow drainag resident be transfer	p.m., the family transported the					
	The Physician's Ord 4/3/22 to 4/7/22, Barng twice a day for 4/7/22 to 4/10/22, It day for five days. 4/13/22 to 4/21/22, extremities twice a 4/21/22 to 6/9/22, but extremities daily un 6/9/22 to 6/17/22, It cream), to the bilate areas were cleansed non-adhesive pads wrapped with roll go 6/17/22 to 6/28/22, applied twice a day extremities. 6/23/22 to 7/16/22, applied to the bilate	ders were as follows: actrim DS (antibiotic), 800-160 cellulitis. Bactrim DS 800-160 mg twice a bag balm to bilateral lower day until healed. bag balm to bilateral lower ntil healed and as needed. Minerin cream (moisturizing eral lower extremities after the and dried. Then four were to be applied and gauze daily. Minerin cream was to be to the bilateral lower Santyl ointment was to be eral lower extremity open areas					
	three times a day. 7/16/22 to 7/21/22, applied to the open 7/21/22, the bilater cleansed and actico open areas every th	Santyl ointment was to be areas twice a day.  al lower legs were to be at was to be applied to the					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155782		ľ	JILDING	00	COMPL 07/29/	ETED	
	PROVIDER OR SUPPLIER			814 S 6	DDRESS, CITY, STATE, ZIP COD TH ST CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 1 7/26/22.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Director of Nursing Care Nurse at the fa the resident, though the treatments. All a areas when they con last Physician or Nu was dated 3/2/22.	y on 7/27/22 at 2:38 p.m., the (DON) indicated a Wound acility had not been assessing a they had completed some of nurses were to assess the skin impleted the treatments. The arse Practitioner Progress Note					
	Physical, dated 7/20 there was cellulitis warm, edematous, a ulcerations with yel	gency Room History and 5/22 at 3:02 p.m., indicated on the BLE. The legs were red, and had multiple chronic low purulent drainage. The venous stasis dermatitis and s.					
	7/27/22, indicated t were black and pair extremity was 21.2 a depth of 0.1 cm. I with serosanguinou slough and 25% esc was 16 cm by 28 cr a full thickness wou	ulent drainage. It had 25%					
	During an interview DON, indicated she spots in the wounds they were maggots indicated LPN 1 ha	rview, indicated there had been he wounds on the BLE.  7 on 7/27/22 at 2:38 p.m., the was informed there were dark and could not be positive as she had not seen them. She d notified her on 7/16/22 and in the wounds and it was					

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155782		A. BUILDING B. WING	00	COMPLE OT 129/2	TED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	notified the Physicia antibiotic. She had i were to be cleaned were no Physician's peroxide to be used. with the hydrogen p the wounds.  During an interview indicated there defin wounds. She had see on both legs when s and after spraying the She notified the DO Physician ordered at then cleansed and le spoke with the family them about the magnot used the hydrogen.	oked like maggots. LPN 1 had an and received an order for an informed LPN 1 the wounds with hydrogen peroxide. There Orders for the hydrogen LPN 1 had cleaned the areas peroxide. She had not assessed or on 7/27/22 at 3:16 p.m., LPN 1 intely were maggots in the en approximately four of them the unwrapped the dressings are cleanser on the wounds. We and the Physician. The in antibiotic. The legs were eff open to the air. She had ly, though had not informed gots in the wounds. The relates to Complaint in the relates to Complaint						
R 0087	410 IAC 16.2-5-1.3							
Bldg. 00	staff as required to of the facility, inclu following: (1) Initial orientatio (2) A continuing in training program for (3) Provision of su Based on record rev Administrator failed	hall provide the number of carry out all the functions uding the on of all employees.  service education and or all employees.  pervision for all employees.  iew and interview, the	R 0087	The submission of this plan of correction does not indicate a		08/19/2022		
	to a resident with a	provided to a resident, related debriding treatment to a (stage 3) being completed by		admission by White Oak Healt Campus that the findings and allegations contained herein a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155782		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/29/2022			
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP COD		
WHITE OAK HEALTH CAMPUS			814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		II PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG				AG			DATE
	a QMA and not a licensed nurse, for 1 of 3 residents reviewed for provision of care. (Resident				accurate, true representation		
				the quality of care provided, and			
	B)				living environment provided		
	Finding includes:			residents of White Oak Heal Campus. The facility recogn			
	i manig merades.				its obligation to provide legally and		
	Resident B's record	was reviewed on 7/27/22 at			medically necessary care ar	-	
	12:27 p.m. The diag	gnoses included, but were not			services o its residents in ar		
	limited to, dementia	a.			economic and efficient manu	ner.	
					The facility hereby maintains	s it is	
	A Physician's Order, dated 6/23/22, indicated				in substantial compliance wi	th the	
	Santyl ointment (debriding agent) was to be				requirements of participation		
	applied to the bilateral lower extremities' open				skilled health care facilities.		
	areas daily.			this end, the plan of correction			
					shall serve as the credible		
	The Medication Administration Record, dated				allegation of compliance with		
	6/2022, indicated QMA 2 completed the treatment				state and federal requirement		
	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				governing the management		
					facility. It is thus submitted a		
					matter of statute only. The far respectfully requests from the	-	
					department a desk review for		
					substantial compliance.	<b>,</b> 1	
					Resident B was discharge	d from	
					the facility on 7/26/2022 to the		
initialed that the Santyl treatment had been completed by the QMA.				hospital and will not be retur			
				to the facility.	J		
					2)All other residents residing	g on	
An Assisted Living wound care policy, dated 8/11/16 and received from the Administrator as				the assisted living unit poter	itial to		
				be affected by the same def	icient		
current, indicated a Nurse would coordinate the			practice. All residents whom have				
		e of each resident who received			a wound were assessed to e		
	applications of dres	ssings.			proper nursing assessment	was	
	TI OMAR : C	. 1 14 110/2002			completed with treatments.		
		urriculum, dated 10/2003,			3)All QMA's and nurse's edu	ıcated	
indicated the QMA was prohibited from administering a treatment that involved an advanced skin condition, which included areas				on a QMA's Scope of			
				Practice/Basic Curriculum			
		stage 1 (non-blanchable red			including that they cannot administer a treatment that		
	intact skin).	stage 1 (Hon-bianellable led			involves an advanced skin		
intact skiii).				mivolves an auvanceu skill			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 07/29/2022		
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  ID  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
	This Residential tag relates to Complaint IN00381857.			condition. The ED, DHS or designee will audit five randor residents TAR's 5 times wee for 4 weeks, 3 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks are then monthly for 3 months to ensure that QMA's are not completing treatments that are outside of their scope of pract 4) Ongoing compliance with the corrective action plan will occur the DHS and/or designee will present the audits at the mon QAPI meeting as facilitated by Executive Director; audits will discontinued after 6 months if further concerns are identified 5)8/19/2022	kly or 4 or 4 or 4 or 4 or 4 or 4 or 7 or 8		
R 0240 Bldg. 00	activities of daily libased upon individed and activities of daily libased on record reversal failed to ensure a respective of a recessary services a follow up assessment in a small head herroreviewed for falls. (Finding includes:  A Fall Event, dated an unwitnessed fall was a hematoma to neurology assessment.	Deficiency and assistance with ving, shall be provided dual needs and preferences. iew and interview, the facility sident who had fallen received after the fall related to lack of ints after a fall which resulted atoma, for 1 of 3 residents Resident B)  7/20/22 at 10:09 a.m., indicated occurred at 9:30 a.m. There the right top of the head. A	R 0240	The submission of this plan or correction does not indicate a admission by White Oak Heal Campus that the findings and allegations contained herein a accurate, true representation the quality of care provided, a living environment provided to residents of White Oak Health Campus. The facility recognizits obligation to provide legally medically necessary care and services o its residents in an economic and efficient manner. The facility hereby maintains in substantial compliance with	n th are of nd o the n ess y and		

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/29/2022		
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5)  JLD BE COMPLETION COMPLETION DATE		
	indicated there was to be four follow-up assessments after a fall.			requirements of participa skilled health care facilities this end, the plan of corre	es. To ection		
	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			shall serve as the credible allegation of compliance state and federal require governing the management facility. It is thus submitted matter of statute only. The respectfully requests from	with all ments ent of this ed as a ne facility n the		
				department a desk review substantial compliance.  1)Resident B was dischat the facility on 7/26/2022 hospital and will not be re-	rged from to the		
	IN00381857 and II	N00386025.		to the facility.  2)All other residents who fall risk have the potential affected by the same definition practice. An audit of the days of falls was completensure that neurological were completed and appresponse to be complete 3)All nurse's were educated Assisted Living fall policy	al to be icient last 14 ted to checks ropriate d if not. ted on the		
				ensuring that follow up not checks are completed at hours post fall. The DHS designee will audit all fall times weekly for 4 weeks a week for 4 weeks, week weeks and then monthly months to ensure that approximately	eurology least 72 or events 5 s, 3 times kly for 4 for 3 propriate		
				assessments are being of for 72 hours after resider 4)Ongoing compliance w corrective action plan will the DHS and/or designed present the audits at the	nt falls. rith this I occur as e will		

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STATEMEN	T OF DEFICIENCIES	OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	N OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u>		00	COMPLETED			
155782		155782	B. WING		07/29/2022		
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				QAPI meeting as facilitated by Executive Director; audits will discontinued after 6 months if further concerns are identified 5)8/19/2022	be no		

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