STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155782	A. BUILDING 00 B. WING	03/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00447557 and IN00448519. This visit included a State Residential Licensure Survey. Complaint IN00447557 - No deficiencies related to the allegations are cited. Complaint IN00448519 - No deficiencies related to the allegations are cited. Survey dates: March 3, 4, 5, 6, 7, and 10, 2025 Facility number: 012355 Provider number: 155782 AIM number: 201014410 Census Bed Type: SNF/NF: 31 SNF: 21 Residential: 55 Total: 107 Census Payor Type: Medicare: 18 Medicaid: 28 Other: 6 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/13/25.	F 0000		
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Anderson	Executive Director	03/29/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on observation, record review, and interview, the facility failed to provide proper feeding tube (gastrostomy tube) (g-tube) care as per professional standards, related to verification of the g-tube placement not completed prior to medication administration for 1 of 1 resident reviewed for feeding tube care. (Resident 29) Finding includes: During an observation of medication pass on 3/5/25 at 12:24 p.m., RN 1 was observed preparing and administering g-tube medications to Resident 29. RN 1 prepared and crushed carbidopa-levodopa (treatment for Parkinson's disease) 25 milligram-100 milligram 2 tablets and glycopyrrolate (treatment for ulcers) 1 milligram tablet in separate medication pouches and then put them into separate medication cups after they were crushed. She washed her hands, donned a gown and gloves, and entered the resident's room. She mixed each medication with approximately 15 milliliters (ml) of water. She flushed the g-tube with 30 ml of water, milked the tubing as the water was not going down by gravity, and then pushed the plunger of the syringe to get the water to flow. She did not check for placement of the g-tube prior to administering the water flush. RN 1 then poured approximately half of the medication cup containing the carbidopa-levodopa into the g-tube. The crushed medication was not mixed in with the water. She flushed the g-tube with 30 ml of water and then administered the glycopyrrolate. She removed her gown and gloves, performed hand hygiene, and exited the room to retrieve a spoon to mix the remaining medication, leaving the medication on the resident's bedside table. She returned and administered the rest of the medication, and flushed the g-tube with water.	F 0693	The submission of this plan of correction does not indicate and admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1 Resident 29 had potential to be affected by the deficient practice. No adverse effects have been noted from the deficient practice. 2 All residents residing in the facility that receives tube feeding administrations have the potential to be affected. A review of all residents receiving tube feeding administrations was completed on 3/21/2025 with no additional	03/27/2025

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	During an interview at the time, RN 1 indicated that the policy was to check for placement once a shift, so she had checked before the morning medication pass and did not have to do check for placement again for the afternoon medication pass. During an interview on 3/7/25 at 12:15 p.m., the Director of Nursing indicated the nursing staff were to check for placement prior to every medication administration. A facility policy titled, "Administering Gastric/Jejunostomy Tube Medications," and noted as current, indicated, "...4. Before administering medications observe or review:....e. vital signs and bowel sounds as indicated; and f. Residual volume of stomach contents...18. Perform any pre-administration assessments..23. There are multiple methods for verifying placement of the tube...a. Checking gastric residual volume (GRV)...c. pH of GRV...e. Observing changes in external length of tubing...g. For all gastric tubes, pull back gently on the syringe to aspirate stomach content...26. Administer medication by gravity flow..." 3.1-44(a)(2)		concerns identified. 3 DHS educated all nurses on the tube feeding administration policy and the importance of checking for placement prior to administering medications. The DHS and/or designee will complete observations of tube feeding administrations including checking for placement 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks, and then monthly for 3 months. 4 Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QA meetings as facilitated by the Executive Director. Audits will be discontinued after 6 months if no further concerns are identified. 5 The systematic changes for this deficiency will be completed by March 27, 2025.	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On Based on observation, record review and interview, the facility failed to identify or act on an irregularity in a resident's medication regimen related to a recommended lab not being completed and an accepted recommendation with no follow up for 2 of 5 residents reviewed for unnecessary medications. (Residents 16 and 8)	F 0756	The submission of this plan of correction does not indicate and admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the	03/27/2025

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	Findings include: 1. Resident 16's record was reviewed on 3/5/25 at 8:45 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depression and anemia. The Quarterly Minimum Data Set assessment, dated 1/9/25, indicated the resident had severe cognitive deficits and required substantial assistance for toileting and transfers. A Pharmacy Recommendation, dated 11/19/24, indicated the resident had an order for an iron supplement for over six months and to consider checking serum iron, ferritin, TIBC and percent transferrin saturation (blood tests to determine iron iron levels) to determine if there was a continued need for supplementation. The recommendation was denied per PCP (primary care physician). There was no documentation for why the recommendation was denied. During an interview on 3/6/25 at 8:57 a.m., the Director of Nursing (DON) indicated the physician was aware of the pharmacy recommendation, but didn't want to put the resident under the stress of a blood draw for only one lab. The DON indicated the rationale had not been documented. 2. Resident 8's record was reviewed on 3/6/25 at 11:18 a.m. Diagnoses included, but were not limited to, situational depression adjustment disorder with depressed mood, cerebral infarction, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 1/17/25, indicated the resident was moderately cognitively impaired for daily decision making. She required substantial staff assistance for activities of daily living (ADL)		residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1 Resident's 16 and 8 had the potential to be affected by the deficient practice. No adverse effects have been noted from the alleged deficient practice. Resident 16 was seen by the physician and rationale for him not ordering labs as suggested in the pharmacy recommendation was documented and family was notified and in agreement with the physician's plan of care. Resident 8's Zoloft was decreased as a GDR attempt. IDT note documented in resident's chart identifying that recommendation was accepted and daughter is in agreement with current plan of care.	

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	tasks including toileting, showering, and transfers. She received antidepressants, anticoagulants, diuretics, and opioid medications during the 7-day look-back period. The current March 2025 Physician Order Summary indicated the resident received 100 milligrams sertraline (antidepressant medication) daily. A Care Plan, dated 2/7/24, indicated the resident received a psychotropic drug and was at risk for developing adverse effects from the use of the antidepressant medication. Interventions included, but were not limited to, administer medication as ordered and attempt gradual dose reduction (GDR) in two separate quarters during the first year the resident received the medication. A Pharmacist Drug Regimen Review, dated 7/22/24, indicated a recommendation for the GDR of sertraline 75 milligrams (mg) to a dose of 50 mg per day. The recommendation was denied with a rationale that there was a clinical contraindication because the resident was on hospice care. A Pharmacist Drug Regimen Review, dated 1/16/25, indicated to consider a trial dose reduction of sertraline 75 mg. The recommendation was marked as accepted. The recommendation to GDR the sertraline was not implemented. During an interview on 3/7/25 at 12:05 p.m., the Director of Nursing indicated they wanted to try the GDR. The resident had been doing well lately and getting up and going to the dining room more often. The facility staff had not met with the family yet to make sure that they were in agreement with the plan of care. A care plan meeting had been set		2 All residents that reside in the facility with pharmacy recommendations that have not been accepted have the potential to be affected. A review of all residents that had pharmacy recommendations in the last 3 months completed on 3/21/2025 with no additional findings. 3 Nursing management was educated by the ED on ensuring that all pharmacy recommendations that are not accepted are marked appropriately on the observation and that a rationale is documented in the resident's chart on why the recommendation is not being accepted. The DHS and/or designee will complete audits for all residents with a new pharmacy recommendation on ensuring that the observation is correct, and a rationale is in place if the recommendation is not accepted. These audits will be completed 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks, and then monthly for 3 months. 4 Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QA meeting as facilitated by the Executive Director. The audits will be discontinued after 6 months if no further concerns are identified. 5 The systematic changes for	

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	up in February, however the family did not attend. She indicated the hospice company was not in agreement for the GDR, but was unsure why the recommendation was marked as accepted. 3.1-25(i)		this deficiency will be completed by March 27, 2025.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being related to lack of non-pharmacological interventions used prior to giving anti-anxiety medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 252) Finding includes: Resident 252's record was reviewed on 3/4/25 at 3:40 p.m. Diagnoses included, but were not limited to, Parkinson's disease, bipolar disorder, and anxiety disorder. The Admission Minimum Data Set (MDS) assessment, dated 3/2/25, was still in progress. A Care Plan, dated 2/25/25, indicated the resident was at risk for adverse consequences related to receiving anxiolytic medications. Interventions included, but were not limited to, attempt non-pharmacological interventions prior to administering as needed (PRN) anxiolytics and administer per orders. The current March 2025 Physician Order Summary indicated clonazepam (anxiolytic) 2 milligrams 1	F 0758	The submission of this plan of correction does not indicate and admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1 Resident 252 had the	03/27/2025

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	tablet as needed for anxiety. The February and March 2025 Medication Administration Record (MAR) indicated the resident received the PRN clonazepam on 2/26 at 8:08 p.m., 2/27 at 6:41 p.m., 2/28 at 8:05 p.m., 3/2 at 7:10 p.m., 3/3 at 8:15 p.m., 3/4 at 7:45 p.m., and 3/5/25 at 1:42 a.m. The record lacked documentation of non-pharmacological interventions attempted prior to administering the PRN doses of clonazepam. During an interview on 3/7/25 at 11:53 a.m. the Director of Nursing indicated she had no further information to provide. 3.1-48(b)(2)		potential to be affected by the alleged deficient practice. No adverse effects were noted from the alleged deficient practice. An order was implemented in Resident 252's chart ensuring that non-pharmalogical interventions are attempted and documented prior to administering a PRN anxiolytic. 2 All residents receiving PRN psychotropic medication have the potential to be affected. A review of all residents who have an order for a PRN psychotropic medication was completed on 3/21/2025 with no additional residents identified. 3 The DHS educated all staff on the importance of ensuring that each resident that receives a PRN psychotropic medication is provided non-pharmalogical interventions prior to administration and that interventions are documented in the resident's chart with the use of the appropriate order set. The DHS and/or designee will complete audits for all residents receiving PRN psychotropic medications 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks, and then monthly for 3 months. 4 Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QA meeting as facilitated	

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			by the Executive Director. The audits will be discontinued after 6 months if no further concerns are identified. 5 The systematic changes for this deficiency will be completed by March 27, 2025.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to ensure a medication was kept in a locked medication cart at all times for 1 of 8 residents observed during medication administration. (Resident 29) Finding includes: During an observation of medication pass on 3/5/25 at 12:24 p.m., RN 1 was observed preparing and administering g-tube medications to Resident 29. RN 1 prepared and crushed carbidopa-levodopa (treatment for Parkinson's disease) 25 milligram-100 milligram 2 tablets and glycopyrrolate (treatment for ulcers) 1 milligram tablet in separate medication pouches and then put them into separate medication cups after they were crushed. She washed her hands, donned a gown and gloves, and entered the residents room. She mixed each medication with approximately 15 milliliters (ml) of water. She flushed the g-tube with 30 mls of water, milked the tubing as the water was not going down by gravity, and then pushed the plunger of the syringe to get the water to flow. She did not check for placement of the g-tube prior to administering the water flush. RN 1 then poured approximately half of the medication cup containing the carbidopa-levodopa into the g-tube. The crushed medication was not mixed in	F 0761	The submission of this plan of correction does not indicate and admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	03/27/2025

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	with the water. She flushed the g-tube with 30 ml of water and then administered the glycopyrrolate. She removed her gown and gloves, performed hand hygiene, and exited the room to retrieve a spoon to mix the remaining medication, leaving the medication on the resident's bedside table. She returned and administered the rest of the medication, and flushed the g-tube with water. During an interview at the time, RN 1 indicated she should not have left the medication at the bedside. During an interview on 3/7/25 at 12:15 p.m., the Director of Nursing indicated the nurse should not have left the medication at the bedside. 3.1-25(m)		1 Resident 29 had the potential to be affected by alleged deficient practice. No adverse effects have been noted from the alleged deficient practice. 2 All residents residing in the facility have the potential to be affected. A review of all residents receiving tube feeding administrations was completed on 3/21/2025 with no additional concerns identified. 3 The DHS educated all staff on the storage of medications even if exiting the room to retrieve an item. The DHS and/or designee will complete audits of medication administrations 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 months, and then monthly for 3 months. 4 Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QA meeting as facilitated by the Executive Director. Audits will be discontinued after 6 months if no additional concerns are identified. 5 The systematic changes for this deficiency will be completed by March 27, 2025.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to a build up of	F 0812	The submission of this plan of correction does not indicate and admission by White Oak Health	03/27/2025

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	food debris and grease on the sides of the oven, deep fryer, floor between the oven and deep fryer, and in the bottom front of a closed warming food cart. The facility also failed to have boxes of food not stored up to the ceiling in the walk in freezer. This had the potential to affect 52 of 52 residents who resided in the facility and received food from the kitchen. (Main Kitchen) Findings include: During the Initial Kitchen Sanitation Tour on 3/3/25 at 10:53 a.m., with the Director of Food Services, the following was observed: a. There was a build up of food debris and grease on the sides of the oven. b. There was a build up of food debris and grease on the sides of the deep fryer. c. There was a build up of food debris and grease on the floor between the oven and the deep fryer. d. There was a build up of food debris and grease in the bottom front of a closed warming food cart. e. There were multiple boxes of food stored up to the ceiling in the walk in freezer. During an interview on the tour, the Director of Food Services indicated the boxes should not be stored up to the ceiling in the walk in freezer and the appliances and floors should be cleaned more often and not have a build up of food and grease. An Aides Cleaning List, provided by the Executive Director on 3/10/25, indicated the kitchen staff were responsible to sweep/mop the kitchen floors daily and clean utility carts weekly.		Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1 No residents were identified to have been affected by the deficient practice. 2 All residents residing in the facility have the potential to be affected by the deficient practice. The identified areas of the sides of the oven, sides of the deep fryer, the floor between the oven and deep fryer, and the warming food cart were immediately cleaned. The boxes stored in the ceiling in the walk-in freezer were removed. A marking to indicate appropriate	

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	The Executive Director could not provide any facility policies for the above concerns. 3.1-21(i)(3)		storage height in the freezer was placed to ensure ongoing compliance. 3 The DFS educated all dietary staff on the importance of maintaining a clean kitchen and the use of the cleaning lists. The DFS and/or designee will complete audits of the dietary staff assigned cleaning lists for completion and ensure such with observation of the assigned cleaning. These audits will be completed 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks, and then monthly for 3 months. 4 Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QA meeting as facilitated by the Executive Director. Audits will be discontinued after 6 months if no additional concerns are identified. !--[endif]-->The systematic changes for this deficiency will be completed by March 27, 2025.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00447557 and IN00448519. Complaint IN00447557 - No deficiencies related to	R 0000		

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	the allegations are cited. Complaint IN00448519 - No deficiencies related to the allegations are cited. Survey dates: March 3, 4, 5, 6, 7, and 10, 2025 Facility number: 012355 Residential Census: 55 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/13/25.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure service plans were signed and/ or updated with changes related to oxygen, mental health services, hospice services, and home health services for 4 of 7 service plans reviewed. (Residents 2, 3, 5, and 7) Findings include: 1. Record review for Resident 2 was completed on 3/7/25 at 1:00 p.m. Diagnoses included, but were not limited to, hyperlipidemia, peripheral vascular disease, and diabetes mellitus A Physician's Order, dated 12/13/23, indicated the resident was to have oxygen at 2 liters per nasal cannula at bedtime. A Service Plan, dated 12/12/24, indicated the resident was cognitively intact. The section for oxygen was not marked that the resident received	R 0217	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all	03/27/2025

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	oxygen treatments. During an interview on 3/10/25 at 12:26 p.m., the Administrator indicated the resident's service plan did not include she received oxygen treatment and it should have been marked.2. Resident 3's record was reviewed on 3/7/25 at 2:51 p.m. Diagnoses included, but were not limited to, anxiety disorder, major depressive disorder, and Alzheimer's disease. The resident was readmitted to the facility on 3/7/24. The Mental Health Services Consult Notes indicated the resident had been seen on 3/7/25, 2/20/25, 2/11/25, and 2/7/25. A Home Health Progress Note, dated 2/3/25, indicated the resident was first seen on 1/10/25 and was receiving occupational therapy, physical therapy and skilled nursing services. The resident was referred by his Physician for urinary catheter management and urinary tract infection. The most recent Service Plan, dated 9/10/24, lacked any documentation or updates to indicate the resident received mental health services or home health services. During an interview on 3/10/25 at 12:25 p.m., the Administrator indicated if there were any updates they would be listed in the box on the last page of the service plan. No further information was provided.3. Resident 5's record was reviewed on 3/7/25 at 3:24 p.m. Diagnoses included, but were not limited to, cognitive communication deficit, atrial fibrillation (irregular heart beat), and high blood pressure. The current March 2025 Physician Order Summary indicated the resident had oxygen at 2 liters per		state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1 Residents 2, 3, 5 and 7 have the potential to be affected by this deficient practice. Service plans for these residents have been updated to include changes related to oxygen, mental health services, hospice services and home health services. All service plans were signed by responsible party. 2 All other residents have the potential to be affected by this deficient practice. All assisted living and Legacy residents service plans were audited by Administrator and/or designee and corrections were made if indicated. 3 Education provided to all nursing staff by Administrator and Director of Assisted Living regarding the accuracy of service plans. Legacy Neighborhood Director, Director of Assisted Living or designee will audit new service plans completed 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and then monthly for 3 months. 4 Ongoing compliance with this corrective action will occur as the LND, DAL or designee will	

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	minute via nasal cannula as needed for shortness of breath and was receiving hospice care. The Service Plan, dated 3/4/25, indicated the resident was severely cognitive impaired and required staff assistance for eating, hygiene care, transfers, and mobility. The service plan did not include the resident receiving oxygen as needed or hospice services. During an interview on 3/10/25 at 12:24 p.m., the Administrator indicated the oxygen and hospice services should have been included on the resident's service plan. 4. Resident 7's closed record was reviewed on 3/10/25 at 12:09 p.m. Diagnoses included, but were not limited to, major depressive disorder with psychotic features, neurocognitive disorder, and anxiety disorders. The Service Plan, dated 10/17/24, indicated the resident was moderately cognitively impaired, received mental health services, and required assistance with medication administration. The service plan was not signed by the resident and/or resident representative. During an interview on 3/10/25 at 4;03 p.m., the Administrator indicated she was unable to locate a signed copy of the service plan.		present the audits at the monthly QAPI meeting facilitated by the Executive Director. Audits will be discontinued after 6 months if no further concerns are noted. 5 The systemic changes for this deficiency will be completed by 3/27/25.	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency Based on observation and interview, the facility failed to ensure medications were given as ordered for 1 of 5 residents observed for	R 0247	The submission of this plan of correction does not indicate an admission by White Oak Health	03/27/2025

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	medication administration. (Resident 3) Finding includes: During a mediation pass observation on 3/7/25 at 4:19 p.m., QMA 1 was observed preparing and administering an insulin injection for Resident 3. She performed hand hygiene, donned gloves, and checked the resident's blood sugar level, which was 167. QMA 1 indicated she would be administering 2 units of insulin per the resident's sliding scale. She performed hand hygiene, donned clean gloves, and prepared the insulin lispro injection. She wiped the insulin lispro pen rubber seal with an alcohol wipe and attached a new needle. She turned the dial on the pen to 2 units, cleaned the injection site with an alcohol wipe, and injected the insulin. QMA 1 did not prime the insulin pen prior to administration of the insulin. She disposed of the needle in the sharps, removed her gloves, and performed hand hygiene. During an interview with QMA 1 at the time, she indicated she should have primed the insulin pen. During an interview on 3/10/25 at 12:37 p.m., the Administrator was notified of the medication error and no further information was provided. The "Instructions for Use of Insulin Lispro KwikPen," indicated, "...Step 1: Wipe the rubber seal with an alcohol swab. Step 2: Check the liquid in the pen...Step 3: Select a new Needle...Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding the pen with the needle pointing up. Push the dose knob in until it stops and "0" is seen in the dose window. Hold the dose knob in and		Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1 1) Resident 3 had the potential to be affected by the deficient practice. BS for this resident was not found to be out of range during subsequent checks that night or the following day. No adverse reaction occurred as a result. QMA was given immediate education regarding insulin administration. 2 2) All residents with insulin injections have the potential to be affected by this deficient practice. 3 3) Education will be provided	

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	count to 5 slowly..."		by DHS or designee to nurses and QMA's regarding insulin administration. Audits will be conducted 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 3 months. 4 4) Ongoing compliance with this action plan will occur as audits will be presented by DHS or designee at the monthly QAPI meetings facilitated by the Executive Director. Audits will be discontinued after 6 months if there are no further concerns identified. 5 5) The systemic changes for this deficiency will be completed by 3/27/25	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to a build up of food debris and grease on the sides of the oven, deep fryer, floor between the oven and deep fryer, and in the bottom front of a closed warming food cart. The facility also failed to have boxes of food not stored up to the ceiling in the walk in freezer. This had the potential to affect 55 of 55 residents who resided in the facility and received food from the kitchen. (Main Kitchen) The facility also failed to store dishes inverted to protect from splash and debris in the memory care unit kitchen. This had the potential to affect 22 of 22 residents who resided in the memory care unit and received food from the kitchen. (Dementia Unit Kitchen)	R 0273	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for	03/27/2025

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	Findings include: 1. During the Initial Kitchen Sanitation Tour on 3/3/25 at 10:53 a.m., with the Director of Food Services, the following was observed: a. There was a build up of food debris and grease on the sides of the oven. b. There was a build up of food debris and grease on the sides of the deep fryer. c. There was a build up of food debris and grease on the floor between the oven and the deep fryer. d. There was a build up of food debris and grease in the bottom front of a closed warming food cart. e. There were multiple boxes of food stored up to the ceiling in the walk in freezer. During an interview on the tour, the Director of Food Services indicated the boxes should not be stored up to the ceiling in the walk in freezer and the appliances and floors should be cleaned more often and not have a build up of food and grease. An Aides Cleaning List provided by the Executive Director on 3/10/25, indicated the kitchen staff were responsible to sweep/mop kitchen floors daily and clean utility carts weekly. 2. During the Initial Kitchen Sanitation Tour on the Dementia Unit on 3/10/25 at 10:18 a.m., with Cook 1, the following was observed: - There were bowls and plates stacked up and stored upright on a shelf in the kitchen across from the stove and also in a box underneath the shelf.		skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1 1) No residents were identified to have been affected by the deficient practice. 2 **2)** All residents residing in the facility have the potential to be affected by the deficient practice. The identified areas of the sides of the oven, sides of the deep fryer, the floor between the oven and deep fryer, and the warming food cart were immediately cleaned. The boxes stored in the ceiling in the walk-in freezer were removed. A marking to indicate appropriate storage height in the freezer was placed to ensure ongoing compliance. Dishes stored upright in the Legacy kitchen were immediately moved to store inverted. 3 3) The DFS educated all dietary staff on the importance of maintaining a clean kitchen, the use of the cleaning lists, and appropriate storage of dishes being inverted if not covered. The DFS and/or designee will complete audits of the dietary staff	

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	During an interview on the tour, Cook 1 indicated the dishes were used to plate the food for the residents. The dishes should be stacked inverted and he would fix them. He also indicated that a lot of the main dishes are cooked in the Main Kitchen and brought to the Dementia Unit Kitchen to be served. The Executive Director could not provide any facility policies for the above concerns.		assigned cleaning lists for completion and ensure such with observation of the assigned cleaning as well as that dishes are stored inverted or covered. These audits will be completed 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks, and then monthly for 3 months. 4 4) Ongoing compliance with this corrective action plan will occur as the DHS and/or designee will present the audits at the monthly QA meeting as facilitated by the Executive Director. Audits will be discontinued after 6 months if no additional concerns are identified. 5 5) The systematic changes for this deficiency will be completed by March 27, 2025.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure the resident Emergency Binder contained all the necessary information for 4 of 5 residents reviewed. (Residents 2, 3, 5 and 6) Findings include: The resident Emergency Binder was reviewed on 3/10/25 at 9:45 a.m.. a. Resident 2 was missing a hospital preference. b. Resident 3 was missing a hospital preference.	R 0356	The submission of this plan of correction does not indicate an admission by White Oak Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of White Oak Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is	03/27/2025

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	c. Resident 5 was missing a hospital preference. d. Resident 6 was missing a hospital preference. During an interview on 3/10/25 at 10:06 a.m., the Assisted Living Director indicated the face sheets had been updated in the computer, but not placed in the binder yet.		in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. 1 1) Residents 2, 3, 5 and 6 had the potential to be affected by this noncompliance. Resident face sheets were printed with the hospital preference and placed in the emergency binder immediately. 2 2) All residents have the potential to be affected. An audit was completed by the Executive Director and Administrator and all resident face sheets were updated and placed in the emergency binders immediately. 3 3) Education will be provided to the nursing staff regarding requirements for the emergency binders by the DHS or designee. Audits of the emergency binders by the LND, DAL or designee will occur 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks then monthly for 3 months. 4 4) Ongoing compliance with this action plan will occur as	

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			audits are presented by the DAL, LND or designee in the monthly QAPI meetings facilitated by the Executive Director. Audits will be discontinued after 6 months if there are no further concerns identified. 5 5) The systemic changes for this deficiency will be completed by 3/27/25.	