STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155782	B. W	NG		03/10/	2025
	PROVIDER OR SUPPLIER			814 S 6	ADDRESS, CITY, STATE, ZIP COD TH ST CELLO, IN 47960		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	T	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TENCY)	
F 0000							
F 0000 Bldg. 00	Licensure Survey and IN State Residential Li State Residential Li Complaint IN00447 the allegations are complaint IN00448 the allegations are comp	7557 - No deficiencies related to ited. 7519 -	F 00	000			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgi	mt/Restore Eating Skills					

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

Stephanie Anderson

(X6) DATE

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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STATEMEN	NT 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	ETED
		155782	B. W	NG		03/10/	2025
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
\\/ UTE		2110		814 S 6			
WHILE	OAK HEALTH CAME	205		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(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' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Based on observation	on, record review, and	F 06	593	The submission of this plan of		03/27/2025
		ty failed to provide proper			correction does not indicate ar		
	· ·	ostomy tube) (g-tube) care as			admission by White Oak Healt		
		ndards, related to verification			Campus that the findings and		
		nent not completed prior to			allegations contained herein a	re	
		stration for 1 of 1 resident			accurate, true representation of		
		g tube care. (Resident 29)			the quality of care, and living		
		8 ()			environment provided to the		
	Finding includes:				residents of White Oak Health		
	I mamy merados				Campus. The facility recognize		
	During an observati	ion of medication pass on			its obligation to provide legally		
	_	., RN 1 was observed preparing			medically necessary care and	and	
	_	g-tube medications to Resident			services to its residents in an		
					economic and efficient manne	r	
	29. RN 1 prepared and crushed carbidopa-levodopa (treatment for Parkinson's				The facility hereby maintains it		
		m-100 milligram 2 tablets and			in substantial compliance with		
		atment for ulcers) 1 milligram			requirements of participation for		
		edication pouches and then			skilled health care facilities. To		
	_	ate medication cups after they			this end, the plan of correction		
		washed her hands, donned a			shall serve as the credible		
		nd entered the resident's room.			allegation of compliance with a	SII	
		dication with approximately 15			state and federal requirements		
		rater. She flushed the g-tube			governing the management of		
		; milked the tubing as the water			facility. It is thus submitted as		
		by gravity, and then pushed			matter of statute only. The fac		
		yringe to get the water to flow.			-	ility	
		or placement of the g-tube			respectfully requests from the department a desk review for		
		ng the water flush. RN 1 then			1 .		
					substantial compliance.	14-	
		ely half of the medication cup			1 Resident 29 had potentia	1 10	
		idopa-levodopa into the			be affected by the deficient		
		I medication was not mixed in			practice. No adverse effects ha	ave	
		flushed the g-tube with 30 ml			been noted from the deficient		
		dministered the glycopyrrolate.			practice.		
	_	own and gloves, performed			2 All residents residing in the		
		exited the room to retrieve a			facility that receives tube feedi	-	
	_	maining medication, leaving			administrations have the poter	ntial	
		he resident's bedside table.			to be affected. A review of all		
		Iministered the rest of the			residents receiving tube feedir		
	medication, and flu	shed the g-tube with water.			administrations was completed	d on	
					3/21/2025 with no additional		

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04/03/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155782 B. WING 03/10/2025 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 During an interview at the time, RN 1 indicated concerns identified. that the policy was to check for placement once a DHS educated all nurses on shift, so she had checked before the morning the tube feeding administration medication pass and did not have to do check for policy and the importance of placement again for the afternoon medication checking for placement prior to pass. administering medications. The DHS and/or designee will During an interview on 3/7/25 at 12:15 p.m., the complete observations of tube Director of Nursing indicated the nursing staff feeding administrations including were to check for placement prior to every checking for placement 5 times a medication administration. week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks, A facility policy titled, "Administering and then monthly for 3 months. Gastric/Jejunostomy Tube Medications," and Ongoing compliance with noted as current, indicated, "...4. Before this corrective action plan will administering medications observe or review:....e. occur as the DHS and/or designee vital signs and bowel sounds as indicated; and f. will present the audits at the Residual volume of stomach contents...18. Perform monthly QA meetings as any pre-administration assessments..23. There are facilitated by the Executive multiple methods for verifying placement of the Director. Audits will be tube...a. Checking gastric residual volume discontinued after 6 months if no (GRV)...c. pH of GRV...e. Observing changes in further concerns are identified. external length of tubing...g. For all gastric tubes, The systematic changes for pull back gently on the syringe to aspirate this deficiency will be completed stomach content...26. Administer medication by by March 27, 2025. gravity flow..." 3.1-44(a)(2)F 0756 483.45(c)(1)(2)(4)(5) SS=D Drug Regimen Review, Report Irregular, Act Bldg. 00 Based on observation, record review and F 0756 The submission of this plan of 03/27/2025 interview, the facility failed to identify or act on an correction does not indicate and irregularity in a resident's medication regimen admission by White Oak Health related to a recommended lab not being completed Campus that the findings and and an accepted recommendation with no follow allegations contained herein are up for 2 of 5 residents reviewed for unnecessary accurate, true representation of medications. (Residents 16 and 8) the quality of care, and living environment provided to 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 00 COMPLETED B. WING 03/10/2025 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include: residents of White Oak Health Campus. The facility recognizes 1. Resident 16's record was reviewed on 3/5/25 at its obligation to provide legally and 8:45 a.m. Diagnoses included, but were not limited medically necessary care and to, Alzheimer's disease, major depression and services to its residents in an anemia. economic and efficient manner. The facility hereby maintains it is The Quarterly Minimum Data Set assessment, in substantial compliance with the dated 1/9/25, indicated the resident had severe requirements of participation for cognitive deficits and required substantial skilled health care facilities. To assistance for toileting and transfers. this end, the plan of correction shall serve as the credible A Pharmacy Recommendation, dated 11/19/24, allegation of compliance with all indicated the resident had an order for an iron state and federal requirements supplement for over six months and to consider governing the management of this checking serum iron, ferritin, TIBC and percent facility. It is thus submitted as a transferrin saturation (blood tests to determine matter of statute only. The facility iron iron levels) to determine if there was a respectfully requests from the continued need for supplementation. The department a desk review for recommendation was denied per PCP (primary care substantial compliance. physician). There was no documentation for why the recommendation was denied. Resident's 16 and 8 had the potential to be affected by the During an interview on 3/6/25 at 8:57 a.m., the deficient practice. No adverse Director of Nursing (DON) indicated the physician effects have been noted from the was aware of the pharmacy recommendation, but alleged deficient practice. didn't want to put the resident under the stress of Resident 16 was seen by the a blood draw for only one lab. The DON indicated physician and rationale for him not the rationale had not been documented. 2. ordering labs as suggested in the Resident 8's record was reviewed on 3/6/25 at pharmacy recommendation was 11:18 a.m. Diagnoses included, but were not documented and family was limited to, situational depression adjustment notified and in agreement with the disorder with depressed mood, cerebral infarction, physician's plan of care. Resident and major depressive disorder. 8's Zoloft was decreased as a GDR attempt. IDT note The Quarterly Minimum Data Set (MDS) documented in resident's chart assessment, dated 1/17/25, indicated the resident identifying that recommendation was moderately cognitively impaired for daily was accepted and daughter is in decision making. She required substantial staff agreement with current plan of assistance for activities of daily living (ADL) care.

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STREET ADDRESS, CITY, STATE, ZIP COD		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	(X2) MULTIPLE C A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 03/10/2025
REFIX TAG REGULATORY OR LSC IDENTIFYING NATIONAL TAG REGULATORY OR L				814 S	6TH ST	
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 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	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION PRIATE
the plan of care. A care plan meeting had been set 5 The systematic changes for	TAG	tasks including toild transfers. She receivanticoagulants, diur during the 7-day loo The current March indicated the reside sertraline (antidepred) A Care Plan, dated received a psychotr developing adverse antidepressant med included, but were medication as order reduction (GDR) in the first year the residency of sertraline 75 milliper day. The recommationale that there because the residency A Pharmacist Drug 1/16/25, indicated the reduction of sertraline recommendation with the first year the residency of the recommendation with the recommendation of the recommendation of the recommendation of the residuant getting up and gotten. The facility syet to make sure the	eting, showering, and wed antidepressants, retics, and opioid medications ok-back period. 2025 Physician Order Summary intreceived 100 milligrams essant medication) daily. 2/7/24, indicated the resident opic drug and was at risk for effects from the use of the ication. Interventions not limited to, administer red and attempt gradual dose two separate quarters during sident received the medication. Regimen Review, dated a recommendation for the GDR digrams (mg) to a dose of 50 mg mendation was denied with a was a clinical contraindication to twas on hospice care. Regimen Review, dated o consider a trial dose in 75 mg. The as marked as accepted. On to GDR the sertraline was word of 3/7/25 at 12:05 p.m., the stindicated they wanted to try ent had been doing well lately going to the dining room more traff had not met with the family at they were in agreement with	TAG	2 All residents that residents the facility with pharmacy recommendations that have been accepted have the pot to be affected. A review of residents that had pharmacy recommendations in the last months completed on 3/21, with no additional findings. 3 Nursing management educated by the ED on ensithat all pharmacy recommendations that are accepted are marked appropriate on the observation and that rationale is documented in resident's chart on why the recommendation is not being accepted. The DHS and/or designee will complete audiall residents with a new pharecommendation on ensuring the observation is correct, arationale is in place if the recommendation is not accepted. The phase audits will be completed as week for 4 weeks, a week for 4 weeks, a week for 4 weeks, a week for 4 weeks, and then monthly for months. 4 Ongoing compliance of this corrective action plan woccur as the DHS and/or diagrams. All the monthly QA meeting as fact by the Executive Director. The audits will be discontinued months if no further concertidentified.	de in e not otential all cy st 3 /2025 was suring not opriately it a the end of armacy ing that and a septed. eted 5 3 times by for 4 or 3 with will esignee be cilitated The after 6 rns are

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155782		(X2) MULTIPLE (A. BUILDING B. WING			
	ROVIDER OR SUPPLIER		814 S	FADDRESS, CITY, STATE, ZIP COD 6TH ST FICELLO, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
E 0750	She indicated the hoagreement for the Grecommendation was 3.1-25(i)	vever the family did not attend. pospice company was not in siDR, but was unsure why the as marked as accepted.		this deficiency will be complete by March 27, 2025.	ed
F 0758 SS=D Bldg. 00	Use	Psychotropic Meds/PRN			
	failed to ensure each regimen was manag or maintain the resist mental, physical, and related to lack of not interventions used produced interventions used produced interventions used produced from the produced	orior to giving anti-anxiety 5 residents reviewed for ations. (Resident 252) and was reviewed on 3/4/25 at as included, but were not limited ase, bipolar disorder, and animum Data Set (MDS) /2/25, was still in progress. 2/25/25, indicated the resident are consequences related to a medications. Interventions anot limited to, attempt al interventions prior to and animum decided (PRN) anxiolytics and	F 0758	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 of the quality of care, and living environment provided to the residents of White Oak Health Campus. The facility recognize its obligation to provide legally medically necessary care and services to 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 allegation of compliance with a state and federal requirements governing the management of facility. It is thus submitted as a matter of statute only. The facil respectfully requests from the department a desk review for substantial compliance.	this

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COMP	ESURVEY LETED 0/2025
	PROVIDER OR SUPPLIEI		814 S	ADDRESS, CITY, STATE, ZIP CO 6TH ST ICELLO, IN 47960	DD .	
(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 CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
	The February and M Administration Recresident received the 8:08 p.m., 2/27 at 6 7:10 p.m., 3/3 at 8: 3/5/25 at 1:42 a.m. The record lacked on non-pharmacologic prior to administeric clonazepam.	March 2025 Medication cord (MAR) indicated the see PRN clonazepam on 2/26 at s:41 p.m., 2/28 at 8:05 p.m., 3/2 at 15 p.m., 3/4 at 7:45 p.m., and documentation of al interventions attempted ng the PRN doses of v on 3/7/25 at 11:53 a.m. the g indicated she had no further		potential to be affected alleged deficient practice adverse effects were not the alleged deficient practice are attempted and docuprior to administering a anxiolytic. 2 All residents receives psychotropic medication potential to be affected. of all residents who have for a PRN psychotropic medication was completed and account of the importance of eneach resident that receives psychotropic medication was completed and interventions prior to administration and that interventions prior to administration and that interventions are documn the resident's chart with the appropriate order see DHS and/or designee we complete audits for all receiving PRN psychotromic medications 5 times a weeks, 3 times a weeks, weekly for 4 weeks, weekly for 4 weethen monthly for 3 month 4 Ongoing compliance this corrective action plate occur as the DHS and/owill present the audits are monthly QA meeting as	e. No sted from sted from suring that ventions mented PRN ring PRN shave the A review e an order sted on sonal d all staff suring that ves a PRN shave	

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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	ЛLDING	00	COMPL	ETED
		155782	B. W	ING		03/10/	/2025
NAME OF F	NDOLUDED OD GLIDDLIE			STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R		814 S 6	STH ST		
WHITE C	OAK HEALTH CAM	PUS		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG			DATE
					by the Executive Director. The		
					audits will be discontinued after		
					months if no further concerns identified.	are	
						for	
					5 The systematic changes this deficiency will be complete		
					by March 27, 2025.	c u	
					by March 27, 2025.		
F 0761	483.45(g)(h)(1)(2)					
SS=D	Label/Store Drugs	•					
Bldg. 00		3					
	Based on observati	on and interview, the facility	F 0'	761	The submission of this plan of		03/27/2025
	failed to ensure a m	nedication was kept in a locked			correction does not indicate a	nd	
	medication cart at a	all times for 1 of 8 residents			admission by White Oak Healt	th	
	observed during me	edication administration.			Campus that the findings and		
	(Resident 29)				allegations contained herein a	re	
					accurate, true representation	of	
	Finding includes:				the quality of care, and living		
					environment provided to the		
	-	ion of medication pass on			residents of White Oak Health		
	-	n., RN 1 was observed preparing			Campus. The facility recognize	es	
		g-tube medications to Resident			its obligation to provide legally		
	29. RN 1 prepared				medically necessary care and		
		a (treatment for Parkinson's			services to its residents in an		
		am-100 milligram 2 tablets and			economic and efficient manne		
		atment for ulcers) 1 milligram			The facility hereby maintains i		
	-	nedication pouches and then			in substantial compliance with		
		rate medication cups after they			requirements of participation f		
		washed her hands, donned a			skilled health care facilities. To		
		and entered the residents room.			this end, the plan of correction	l	
		edication with approximately 15			shall serve as the credible		
	` ′	vater. She flushed the g-tube			allegation of compliance with		
		er, milked the tubing as the			state and federal requirements		
		g down by gravity, and then			governing the management of		
		of the syringe to get the water			facility. It is thus submitted as		
		t check for placement of the			matter of statute only. The fac	iiity	
		inistering the water flush. RN 1 timately half of the medication			respectfully requests from the department a desk review for		
		carbidopa-levodopa into the			1 .		
		d medication was not mixed in			substantial compliance.		
	g-tube. The crushed	a medication was not mixed in	1		Í.		I

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	PROVIDER OR SUPPLIER		814 S	TADDRESS, CITY, STATE, ZIP COD 6TH ST FICELLO, 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
F 0812 SS=F	of water and then as She removed her go hand hygiene, and e spoon to mix the rethe medication on the She returned and admedication, and flus During an interview she should not have bedside. During an interview Director of Nursing not have left the medication.	flushed the g-tube with 30 ml dministered the glycopyrrolate. It was an all gloves, performed exited the room to retrieve a maining medication, leaving the resident's bedside table. It was the graph with water. It was the time, RN 1 indicated left the medication at the room 3/7/25 at 12:15 p.m., the indicated the nurse should dication at the bedside.		1 Resident 29 had the pote to be affected by alleged deficipractice. No adverse effects heen 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 3/21/2025 with no additional concerns identified. 3 The DHS educated all stone the storage of medications even if exiting the room to retrain item. The DHS and/or desivill complete audits of medical administrations 5 times a week 4 weeks, 3 times a week for 4 weeks, weekly for 4 months. 4 Ongoing compliance with this corrective action plan will occur as the DHS and/or desivill present the audits at the monthly QA meeting as facilities by the Executive Director. Audit will be discontinued after 6 medifined additional concerns are identified. 5 The systematic changes this deficiency will be completed by March 27, 2025.	cient lave he elects d on aff rieve ignee ation lk for for for
Bldg. 00	Based on observation interview, the facility	e/Prepare/Serve-Sanitary on, record review, and ty failed to keep the kitchen epair related to a build up of	F 0812	The submission of this plan of correction does not indicate a admission by White Oak Heal	nd

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/10/2025 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 food debris and grease on the sides of the oven, Campus that the findings and deep fryer, floor between the oven and deep fryer, allegations contained herein are and in the bottom front of a closed warming food accurate, true representation of cart. The facility also failed to have boxes of food the quality of care, and living not stored up to the ceiling in the walk in freezer. environment provided to the This had the potential to affect 52 of 52 residents residents of White Oak Health who resided in the facility and received food from Campus. The facility recognizes the kitchen. (Main Kitchen) its obligation to provide legally and medically necessary care and Findings include: services to its residents in an economic and efficient manner. During the Initial Kitchen Sanitation Tour on The facility hereby maintains it is 3/3/25 at 10:53 a.m., with the Director of Food in substantial compliance with the Services, the following was observed: requirements of participation for skilled health care facilities. To a. There was a build up of food debris and grease this end, the plan of correction on the sides of the oven. shall serve as the credible allegation of compliance with all b. There was a build up of food debris and grease state and federal requirements on the sides of the deep fryer. governing the management of this facility. It is thus submitted as a c. There was a build up of food debris and grease matter of statute only. The facility on the floor between the oven and the deep fryer. respectfully requests from the department a desk review for d. There was a build up of food debris and grease substantial compliance. in the bottom front of a closed warming food cart. No residents were identified e. There were multiple boxes of food stored up to to have been affected by the the ceiling in the walk in freezer. deficient practice. All residents residing in the During an interview on the tour, the Director of facility have the potential to be Food Services indicated the boxes should not be affected by the deficient practice. stored up to the ceiling in the walk in freezer and The identified areas of the sides of the appliances and floors should be cleaned more the oven, sides of the deep frver. often and not have a build up of food and grease. the floor between the oven and deep fryer, and the warming food An Aides Cleaning List, provided by the cart were immediately cleaned. Executive Director on 3/10/25, indicated the The boxes stored in the ceiling in kitchen staff were responsible to sweep/mop the the walk-in freezer were removed. kitchen floors daily and clean utility carts weekly. A marking to indicate appropriate

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	
		155782	B. WING			03/10/	2025
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD		
WHITE C	OAK HEALTH CAM	DUIC		14 S 67	CELLO, IN 47960		
	TARTIEALTIT CAW				DELLO, IN 47 900	,	
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		EFIX AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		ector could not provide any the above concerns.			storage height in the freezer was placed to ensure ongoing compliance. 3 The DFS educated all diestaff on the importance of maintaining a clean kitchen are the use of the cleaning lists. T DFS and/or designee will	etary nd he	
					complete audits of the dietary assigned cleaning lists for completion and ensure such vobservation of the assigned cleaning. These audits will be completed 5 times a week for weeks, 3 times a week for 4 weeks, weekly for 4 weeks, ar then monthly for 3 months. 4 Ongoing compliance with this corrective action plan will occur as the DHS and/or design will present the audits at the monthly QA meeting as facilitate by the Executive Director. Audith will be discontinued after 6 month of the discontinued after 6 mont	vith 4 Ind gnee ated dits onths	
R 0000							
Bldg. 00	Survey. This visit is State Licensure Su Nursing Home Con IN00448519.	a State Residential Licensure neluded a Recertification and rvey and the Investigation of applaints IN00447557 and	R 0000				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155782 (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING			(X3) DATE : COMPL 03/10/	ETED			
	PROVIDER OR SUPPLIER			814 S 6	DDRESS, CITY, STATE, ZIP COD TH ST CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
R 0217 Bldg. 00	the allegations are consumers. Survey dates: Marco Facility number: 01. Residential Census: These State Resident central Place Central Census: These State Resident central Census: These State Residential Census: These State Residential Census: These State Residential Census: These State Resident central Census: These State Resident central Census: These State Resident central Census: These State Residential Census: Th	519 - No deficiencies related to ited. h 3, 4, 5, 6, 7, and 10, 2025 2355 55 stial Findings are cited in DIAC 16.2-5. pleted on 3/13/25. e)(1-5) ency iew and interview, the facility rice plans were signed and/ or es related to oxygen, mental pice services, and home of 7 service plans reviewed. and 7) r Resident 2 was completed on Diagnoses included, but were relipidemia, peripheral vascular	R 021	17	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, and living environment provided to the residents of White Oak Health Campus. The facility recognize its obligation to provide legally medically necessary care and services to 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	n th re of and r. t is the or or	03/27/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155782		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/10/2025	
	PROVIDER OR SUPPLIER		814 S	ADDRESS, CITY, STATE, ZIP COD 6TH ST ICELLO, IN 47960	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	oxygen treatments.	LSC IDENTIFYING INFORMATION	TAG	state and federal requirement	
	Administrator indic did not include she it should have been was reviewed on 3/ included, but were major depressive di	on 3/10/25 at 12:26 p.m., the ated the resident's service plan received oxygen treatment and marked.2. Resident 3's record 7/25 at 2:51 p.m. Diagnoses not limited to, anxiety disorder, sorder, and Alzheimer's at was readmitted to the		governing the management of facility. It is thus submitted as matter of statute only. The factor respectfully requests from the department a desk review for substantial compliance. Residents 2, 3, 5 and 7 if the potential to be affected by	a pility nave
	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.			deficient practice. Service pla for these residents have been updated to include changes	ns
				related to oxygen, mental hea services, hospice services an home health services. All serv	d
	indicated the reside and was receiving of therapy and skilled was referred by his	ngress Note, dated 2/3/25, nt was first seen on 1/10/25 occupational therapy, physical nursing services. The resident Physician for urinary catheter inary tract infection.		plans were signed by respons party. 2 All other residents have potential to be affected by this deficient practice. All assisted living and Legacy residents so plans were audited by	ible the
	lacked any docume	rvice Plan, dated 9/10/24, ntation or updates to indicate d mental health services or es.		Administrator and/or designed corrections were made if indicated. 3 Education provided to all nursing staff by Administrator	
	Administrator indice they would be listed the service plan. No provided.3. Resider 3/7/25 at 3:24 p.m. not limited to, cognitatrial fibrillation (ir blood pressure.	on 3/10/25 at 12:25 p.m., the ated if there were any updates in the box on the last page of the further information was at 5's record was reviewed on Diagnoses included, but were attive communication deficit, regular heart beat), and high		Director of Assisted Living regarding the accuracy of semplans. Legacy Neighborhood Director, Director of Assisted Living or designee will audit in service plans completed 5 tim week for 4 weeks, 3 times a wind for 4 weeks, weekly for 4 week and then monthly for 3 month 4. Ongoing compliance with	ew es a veek ks s.
		2025 Physician Order Summary nt had oxygen at 2 liters per		this corrective action will occur the LND, DAL or designee wil	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155782	B. W	ING		03/10/	/2025
				CTREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8		814 S 6			
WHITE C	OAK HEALTH CAME	0110			CELLO, IN 47960		
WITTE	ARTIEALTIT CAWI	-03		WONT	CELLO, IN 47 900		
(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'	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nnula as needed for shortness			present the audits at the mont	-	
	of breath and was re	eceiving hospice care.			QAPI meeting facilitated by the		
					Executive Director. Audits will		
		ated 3/4/25, indicated the			discontinued after 6 months if	no	
		ly cognitive impaired and			further concerns are noted.		
	_	ance for eating, hygiene care,			5 The systemic changes fo		
	transfers, and mobil	lity.			this deficiency will be complete	ed	
	7E1 ' 1 1'	1 4: 1 1 4			by 3/27/25.		
	_	d 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.						
	resident's service pr	un.					
	4. Resident 7's close	ed record was reviewed on					
		n. Diagnoses included, but were					
	_	or depressive disorder with					
	1	neurocognitive disorder, and					
	anxiety disorders.						
	The Service Plan, d	ated 10/17/24, indicated the					
	resident was moder	ately cognitively impaired,					
	received mental hea	alth services, and required					
	assistance with med	lication administration.					
	1	as not signed by the resident					
	and/or resident repr	esentative.					
		2/12/27					
		on 3/10/25 at 4;03 p.m., the					
		ated she was unable to locate					
	a signed copy of the	e service pian.					
R 0247	410 IAC 16.2-5-4(e)(7)					
11 02-11	Health Services -						
Bldg. 00	Ticalin Oct viocs	Donolonoy					
g. 00	Based on observation	on and interview, the facility	R_0	247	The submission of this plan of		03/27/2025
		dications were given as		<u>~</u> 1/	correction does not indicate ar		03/2//2023
		esidents observed for			admission by White Oak Healt		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155782		ì í	ILDING	nstruction 00	(X3) DATE S COMPL 03/10/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD TH ST	00/10/	2020
WHITE C	OAK HEALTH CAMI	PUS		MONTI	CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	medication administration includes: During a mediation 4:19 p.m., QMA 1 administering an in She performed hand checked the resident was 167. QMA 1 in administering 2 unisliding scale. She puring an interview indicated she should buring an in	pass observation on 3/7/25 at was observed preparing and sulin injection for Resident 3. If hygiene, donned gloves, and the blood sugar level, which idicated she would be the of insulin per the resident's terformed hand hygiene, and prepared the insulin the wiped the insulin lispro pen alcohol wipe and attached a med the dial on the pen to 2 dijection site with an alcohol the insulin. QMA 1 did not the prior to administration of the tend of the needle in the sharps, and performed hand hygiene. What is the time, she did have primed the insulin pen. What is the time, she did have primed the insulin pen. What is the time, she did have primed the insulin pen. What is the time, she did have primed the insulin pen. What is the time, she did have primed the insulin pen. What is the time, she did have primed the insulin pen. What is the time, she did have primed the insulin pen. What is the time, she did have primed the insulin pen. What is the time, she did have primed the insulin pen. What is the time, she did have primed the insulin pen. What is the time, she did have primed the insulin pen. What is the time, she did have primed the insulin pen. What is the time, she did have primed the insulin pen. What is the time, she did not the pen to 2 did not the sharps, she did not the sharps and sharp		TAG	Campus that the findings and allegations contained herein a accurate, true representation the quality of care, and living environment provided to the residents of White Oak Health Campus. The facility recognizits obligation to provide legally medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains in substantial compliance with requirements of participation fiskilled health care facilities. To this end, the plan of corrections hall serve as the credible allegation of compliance with state and federal requirements governing the management of facility. It is thus submitted as matter of statute only. The facility 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 crange during subsequent check that night or the following day, adverse reaction occurred as result. QMA was given immediated as the potential to the following day, adverse reaction occurred as result. QMA was given immediated as result. QMA was given immediated as the potential to the following day. All residents with insuling administration. 2 2) All residents with insuling administration. 3 3) Education will be provered.	re of es and er. it is e or on all sillity out of cks No a late in be ice.	DATE

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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 03/10/2025		
		155/82	B. WING 03/10/2025				
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			TE	(X5) COMPLETION DATE
P 0273	count to 5 slowly" 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)				by DHS or designee to nurses QMA's regarding insulin administration. Audits will be conducted 5 times a week for weeks, 3 times a week for 4 weeks, weekly for 4 weeks, th monthly for 3 months. 4 4) Ongoing compliance withis action plan will occur as audits will be presented by Dhidesignee at the monthly QAPI meetings facilitated by the Executive Director. Audits will discontinued after 6 months if there are no further concerns identified. 5 5) The systemic changes this deficiency will be completed by 3/27/25	4 en vith IS or be	
R 0273 Bldg. 00			R 02	273	The submission of this plan of correction does not indicate at admission by White Oak Healt Campus that the findings and allegations contained herein a accurate, true representation of the quality of care, and living environment provided to the residents of White Oak Health Campus. The facility recognizits obligation to provide legally medically necessary care and services to its residents in an economic and efficient manne. The facility hereby maintains it in substantial compliance with requirements of participation for	n re of es and r. t is the	03/27/2025

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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 03/10/2025			
NAME OF I	PROVIDER OR SUPPLIER	?	•		ADDRESS, CITY, STATE, ZIP COD	•	
				814 S 6			
WHITE C	OAK HEALTH CAMI	PUS		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	Findings include:				skilled health care facilities. To		
					this end, the plan of correction	1	
	_	l Kitchen Sanitation Tour on			shall serve as the credible		
		., with the Director of Food			allegation of compliance with		
	Services, the follow	ving was observed:			state and federal requirements		
	Tr1 1 '1	1 (C 111: 1			governing the management of		
		d up of food debris and grease			facility. It is thus submitted as		
	on the sides of the	JVCII.			matter of statute only. The fac	-	
	h Thoro was a buil	ld up of food debris and grease			respectfully requests from the		
					department a desk review for		
	on the sides of the deep fryer.				substantial compliance.		
	c. There was a build up of food debris and grease				1 1) No residents were		
	on the floor between the oven and the deep fryer.				identified to have been affecte	ed bv	
					the deficient practice.	,	
	d. There was a build up of food debris and grease				2 2) All residents residing	in	
	in the bottom front of a closed warming food cart.				the facility have the potential t	o be	
					affected by the deficient practi	ce.	
	e. There were multiple boxes of food stored up to the ceiling in the walk in freezer.				The identified areas of the sid	es of	
					the oven, sides of the deep fry	er,	
					the floor between the oven an		
	_	v on the tour, the Director of			deep fryer, and the warming for		
		cated the boxes should not be			cart were immediately cleaned		
		ling in the walk in freezer and			The boxes stored in the ceiling	-	
	the appliances and floors should be cleaned more				the walk-in freezer were remo		
	often and not have a build up of food and grease.				A marking to indicate appropri		
					storage height in the freezer w	/as	
	An Aides Cleaning List provided by the Executive Director on 3/10/25, indicated the kitchen staff			placed to ensure ongoing compliance. Dishes stored upright		riaht	
					in the Legacy kitchen were		
	were responsible to sweep/mop kitchen floors daily and clean utility carts weekly.			immediately moved to store			
	dany and clean utility carts weekly.				inverted.		
	2. During the Initia	l Kitchen Sanitation Tour on			3 3) The DFS educated all		
	the Dementia Unit on 3/10/25 at 10:18 a.m., with				dietary staff on the importance		
	Cook 1, the followi				maintaining a clean kitchen, th		
		-			use of the cleaning lists, and		
	- There were bowls	and plates stacked up and			appropriate storage of dishes		
		shelf in the kitchen across	- [being inverted if not covered.	The	
	from the stove and	also in a box underneath the			DFS and/or designee will		
shelf.				complete audits of the dietary	staff		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			COMPL	COMPLETED		
		155782	B. WING		03/10/2025			
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER				814 S 6				
WHITE C	OAK HEALTH CAME	PUS	MONTICELLO, IN 47960					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	assigned cleaning lists for		DATE	
	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.				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			
R 0356	410 IAC 16.2-5-8.	***			if no additional concerns are identified. 5 5) The systematic change for this deficiency will be completed by March 27, 2025.	es		
DI-I 00	Clinical Records - Noncompliance							
Bldg. 00	failed to ensure the contained all the new residents reviewed. Findings include: The resident Emerg 3/10/25 at 9:45 a.m. a. Resident 2 was m	riew and interview, the facility resident Emergency Binder cessary information for 4 of 5 (Residents 2, 3, 5 and 6) ency Binder was reviewed on dissing a hospital preference.	R 0	356	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, and living environment provided to the residents of White Oak Health Campus. The facility recognize its obligation to provide legally medically necessary care and services to its residents in an economic and efficient manne. The facility hereby maintains it	n re of es and	03/27/2025	

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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 03/10/2025			
	OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 814 S 6TH ST MONTICELLO, IN 47960					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION (X5) LD BE COMPLETION ROPRIATE DATE			
IAG	c. Resident 5 was 1 d. Resident 6 was 1 During an interview Assisted Living Di	missing a hospital preference. missing a hospital preference. w on 3/10/25 at 10:06 a.m., the rector indicated the face sheets in the computer, but not placed	IAG	in substantial compliance requirements of participat skilled health care facilities this end, the plan of corresponding shall serve as the credible allegation of compliance state and federal requirer governing the management facility. It is thus submitte matter of statute only. The respectfully requests from department a desk review substantial compliance. 1 1) Residents 2, 3, 5 had the potential to be affected with a sheets were printed with a hospital preference and put the emergency binder immediately. 2 2) All residents have potential to be affected. A was completed by the Ex Director and Administrator resident face sheets were and placed in the emergency binders immediately. 3 3) Education will be to the nursing staff regard requirements for the emergency by the LND, DAL or design occur 5 times a week for 4 week weekly for 4 weeks then refor 3 months. 4 4) Ongoing compliant this action plan will occur	with the tion for es. To ection e with all ments ent of this d as a e facility in the v for and 6 fected by dent face the elaced in ethe en audit ecutive or and all e updated ency provided ding graency esignee. binders gnee will 4 weeks, ks, monthly ince with			

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AND PLAN OF CORRECTION IDI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155782	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE COMPL 03/10/	LETED	
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	STATEMENT OF DEFICIENCIE NCY 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)	ATE	(X5) COMPLETION DATE	
				audits are presented by the D LND or designee in the month QAPI meetings facilitated by t Executive Director. Audits will discontinued after 6 months if there are no further concerns identified. 5 5) The systemic changes this deficiency will be completed by 3/27/25.	aly he be		

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