STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155782	A. BUILDING -- B. WING	02/09/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/09/23 Facility Number: 012355 Provider Number: 155782 AIM Number: 201014410 At this Emergency Preparedness survey, White Oak Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.90(a) The facility has 61 certified beds. At the time of the survey, the census was 55. Quality Review completed on 02/14/23	E 0000	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 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.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Anderson	Executive Director	02/22/2023

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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	Survey date: 02/09/23 Facility Number: 012355 Provider Number: 155782 AIM Number: 201014410 At this Life Safety Code survey, White Oak Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story, fully sprinklered facility was determined to be Type V (111) construction. The facility has a fire alarm system with hard wired smoke detection in the corridors, areas open to the corridors, and resident rooms. The SNF certified health care occupancy was located on north end of the main building with the capacity for 61 residents and a census of 55 at the time of this survey. All areas accessible to residents and areas providing facility services are sprinklered. Quality Review completed on 02/14/23		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.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview; the facility failed to ensure all fire / smoke dampers in the	K 0521	1) The contracted company was contacted immediately, and	02/24/2023

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	facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 02/09/23 at 10:19 a.m. with the Director of Plant Operations (DPO) and the facility Administrator, the Fire/Smoke Damper Maintenance Record indicated that the approximately 250 fire / smoke dampers located throughout the facility were provided maintenance on 12/07/2018, which is a period exceeding the four-year maintenance requirement. The lack of four-year maintenance conducted on		an inspection date was received. See Attachment #1, certification that the Fire Damper Inspection was completed on February 20, 2023, by SafeCare. 2) All residents have the ability to be affected. 3) As a measure of ongoing compliance, the Director of Plant Operations and/or designee will complete an audit of required testing compliance monthly for 6 months. The Director of Plant Operations was educated on ensuring that Damper Inspections are completed at least every 4 years, see Attachment #2. 4) As a quality measure, the Director of Plant Operations and/or designee will review and report any findings and associated corrective action at least monthly util the campus achieves 100% compliance in the campus QAPI Meetings. The plan will be reviewed and updated as warranted. 5) The systemic changes will be completed by February 24, 2023.	

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	the facilities fire / smoke dampers was verified by the DPO at the time of record review. During the exit conference with the DPO and the facility Administrator on 02/09/23 at 2:01 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			