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	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Health Campus	814 S 6th St Monticello, IN 47960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 45666 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. 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 32582 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) 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. 45666 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) 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. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45666 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 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)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45666 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 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)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32664 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 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. The Executive Director could not provide any facility policies for the above concerns. 3.1-21(i)(3)