STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155837	A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VILLAGES AT OAK RIDGE, THE	1694 TROY ROAD WASHINGTON, IN 47501

(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 Complaint IN00429428. This visit included a State Residential Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00430875. Complaint IN00429428 - No deficiencies related to the allegations are cited. Survey dates: March 19, 20, 21, 25, 26, 27, 2024 Facility number: 013332 Provider number: 155837 AIM number: 201305040 Census Bed Type: SNF: 20 SNF/NF: 33 Residential: 30 Total: 83 Census Payor Type: Medicare: 11 Medicaid: 23 Other: 17 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 8, 2024.	F 0000	The submission of this plan of correction does not indicate an admission by The Villages at Oak Ridge that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of The Villages at Oak Ridge. 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.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lori Hess		04/19/2024

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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	The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			

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	Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect and dignity for 1 of 1 resident reviewed for dignity. Resident was being fed at the nurse's station. (Resident 47) Findings include: On 3/19/24 at 9:30 A.M., upon entrance to the facility, CNA 33 was standing at the 300 hall nurse's station feeding Resident 47, who was sitting in a wheelchair. On 3/25/24 at 11:21 A.M., Resident 47's clinical records were reviewed. She was admitted on 12/13/23. Diagnosis included, but were not limited to, cerebral palsy, epilepsy, and dysphagia. The most current Significant Change in Condition MDS (Minimum Data Set) Assessment, dated 2/5/24 indicated Resident 47's cognitive status was unable to be assessed, extensive assistance of two was needed for bed mobility, transfers and toilet use, and extensive assistance of one was needed for eating. Physician's orders included, but were not limited to the following: Diet: Fortified Foods (therapeutic), Pureed (Texture), honey-thick (Liquid Consistency) Activia every night, dated 3/20/2024 Activity Level: Hoyer Lift for all Transfers Twice A Day 6:00 A.M. - 6:00 P.M., 6:00 P.M. - 6:00 A.M., dated 12/13/2023 During an interview on 3/26/24 at 2:17 P.M., CNA 25 indicated if a resident needed to be fed, they would be fed in their room or in the private dining room. Residents should not be fed at the nurse's	F 0550	1. Residents # 47 suffered no ill effects from the alleged deficient practice. Resident was assessed with no concerns. CNA # 33 immediately educated regarding resident rights and dignity with assistance with feeding. 2. All residents have the potential to be affected. Staff will be educated on resident rights and maintaining dignity. 3. As a measure of ongoing compliance, the DHS or designee will complete rounding audits 5x/week for 4 weeks, then 5x every other week for 2 months, then monthly for 3 months to ensure proper feeding assistance with dignity is maintained. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	04/19/2024

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	station because that was a dignity issue. On 3/25/24 at 11:53 A.M., the DON (Director of Nursing) provided a Resident Rights Guidelines Policy, revised 5/11/17, which indicated "...2. Our residents have a right to...a. Be treated with dignity and respect..." 3.1-3(a)			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure assessments were completed for a resident that self administered medications for 2 of 2 random observations. A resident was observed in a room alone with a medication cup containing pills. (Resident 34) Findings include: On 3/19/24 at 10:25 A.M., Resident 34 was observed sitting in her room. Two medication cups were observed stacked together with applesauce in the top one, and a blue capsule in the bottom one. On 3/19/24 at 11:51 A.M., Resident 34's room was observed with Licensed Practical Nurse (LPN) 21. At that time, Resident 34 was in the dining room. To medication cups were observed still stacked together with applesauce in the top one, and the following medications in the bottom one: 1 round white tablet 1 blue capsule	F 0554	1. Residents # 34 suffered no ill effects from the alleged deficient practice. Medication left at bedside was immediately discarded. Nursing staff were immediately educated on not leaving medications in resident rooms unattended. 2. All residents have the potential to be affected. Nursing staff will be educated on self-administration of medications and not leaving medications in resident rooms unattended. 3. As a measure of ongoing compliance, the DHS or designee will round 4 rooms to ensure medications are not left in resident rooms unattended weekly for 4 weeks, then every other week for 2 months, then monthly for 3 months. The DHS or designee will complete random medical record audits for appropriate completion	04/19/2024

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	1 round rust colored tablet 1 oval peach tablet with a "5" on one side At that time, LPN 21 indicated the medications were not supposed to be in the room, and were probably Resident 34's morning medications. On 3/19/24 at 12:00 P.M., Resident 34's clinical record was reviewed. Diagnosis included, but were not limited to, respiratory failure and coronary artery disease. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 2/14/24, indicated no cognitive impairment and no behaviors. Resident 34's clinical record lacked an order to self administer medications. Resident 34's clinical record lacked care plans to self administer medications. A self administration assessment, dated 7/24/23, indicated Resident 34 could self administer Vick's topical, Vick's nasal spray, and Vick's roll on. The assessment lacked the ability to self administer any other medications. On 3/27/24 at 10:00 A.M., Certified Nurse Aide (CAN) 19 indicated Resident 34 required limited assistance of one staff with activities of daily living. On 3/27/24 at 12:20 P.M., a current Self-Administration of Medications policy, dated 12/31/23, was provided and indicated "Residents requesting to self- medicate or has self-medication as a part of their plan of care shall be assessed ... Results of the assessment will be presented to the physician for evaluation and an order for self-medication"		of self-administration assessment 5x/week for 4 weeks, then 5x every other week for 2 months, then monthly for 3 months 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	3.1-11(a)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the			

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	community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview and record review, the facility failed to implement the care plan for 2 of 2 residents reviewed for implementation of a care plan. The facility failed to fill the oxygen humidification bottle for one resident and failed to give a medication to one resident. (Resident 30, Resident 29) Findings include: 1. On 3/19/24 at 10:59 A.M., Resident 30 was observed lying in bed with her eyes closed. Oxygen (O2) tubing was lying on the floor, the humidification bottle was empty and the oxygen machine was on at 4 l/min (liters per minute). On 3/20/24 at 10:04 A.M., Resident 30's humidification bottle on the oxygen machine was empty. At that time, RN 27 indicated the humidification bottles were changed as needed, usually on the night shift. After she replaced the empty bottle, she indicated she checked the bottles routinely but missed this one. On 3/21/24 at 9:50 A.M., Resident 30's clinical records were reviewed. Diagnosis included, but were not limited to chronic obstructive pulmonary disease, pulmonary fibrosis, and other pulmonary	F 0656	1. Residents # 30 and # 29 suffered no ill effects from the alleged deficient practice. Resident #30's empty oxygen humidification bottle was replaced. Nurse was immediately educated to monitor and change oxygen humidification bottle when empty. Resident #29 was assessed with no concerns. Change in direction sticker placed on current medication container. Qualified Medication Aide (QMA) was immediately educated on notification of medication availability to the nurse and proper documentation. 2. All residents have the potential to be affected. Licensed nursing staff will be educated on monitoring and changing empty oxygen humidification bottles, documentation and proper notification of drug availability, and the care plan policy. 3. As a measure of ongoing compliance, the DHS or designee will round 4 rooms weekly for 4	04/19/2024

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	collapse. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 12/28/23, indicated Resident 30 was cognitively intact, needed supervision with bed mobility, transfer and toilet use and used oxygen. Physician's orders included, but were not limited to the following: Order Set O2 (oxygen)- Change oxygen tubing monthly Once A Day on the 1st of the Month 6:00 P.M. - 6:00 A.M., dated 1/14/2023 Order Set O2- Clean external concentrator filter every two weeks. Once A Day on Sun Every 2 Weeks 11:00 P.M. - 6:00 A.M., dated 1/14/2023 Order Set O2- Oxygen @ (at) 2L (liters)-4L per nasal cannula prn (as needed) and Q HS (every bedtime) for shortness of breath Twice A Day 6:00 A.M. - 10:00 A.M., 06:00 P.M. - 10:00 P.M., dated 3/20/2024 Order Set O2- Assess/Observe for s/s (signs and symptoms) of SOB (shortness of breath) while laying flat Special Instructions: Dx (diagnosis): COPD (Chronic Obstructive Pulmonary Disease) Twice A Day 6:00 A.M. - 6:00 P.M., 6:00 P.M. - 6:00 A.M., dated 6/23/2022 Order Set O2- HOB elevated to alleviate/reduce shortness of breath while lying flat Special Instructions: Dx: COPD Twice A Day		weeks, then every other week for 2 months, then monthly for 3 months to ensure oxygen humidification bottles are not empty. The DHS or designee will audit the MAR/TAR administration compliance 5xs weekly during morning clinical care meeting to ensure medications were administered as available weekly for 4 weeks, then every other week for 2 months, then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	6:00 A.M. - 6:00 P.M., 6:00 P.M. - 6:00 A.M., dated 6/23/2022 Order Set O2- Monitor O2 sats (saturations) Q (every) shift Twice A Day 6:00 P.M. - 06:00 A.M., 6:00 A.M. - 6:00 P.M., dated 10/06/2022 Order Set O2- Oxygen @ 2L per nasal cannula NOC (night) and PRN for shortness of breath Twice A Day 6:00 P.M. - 6:00 A.M., 6:00 A.M. - 6:00 P.M., dated 8/30/2023 and discontinued 3/20/2024. Care plans included: Problem: Resident has potential for complications, functional and cognitive status decline related to respiratory disease d/t (due to) COPD and pulmonary fibrosis. Start Date 8/10/2022 Interventions included, but were not limited to: Approach: Respiratory therapy per orders. Start Date 8/10/2022 Approach: Administer oxygen per orders. Start Date 8/10/2022 Problem: Resident has potential for SOB while lying flat r/t (related to) COPD and pulmonary fibrosis. Start Date 8/10/2022 Interventions included, but were not limited to: Approach: Administer oxygen per MD (Medical Doctor) order and as needed. Start Date 8/10/2022 2. On 3/21/24 at 10:44 A.M., Resident 29's clinical record was reviewed. Diagnosis included, but			

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	were not limited to, traumatic brain injury. The most recent Significant Change MDS (Minimum Data Set) Assessment, dated 3/12/24, indicated a significant cognitive impairment. Current physician orders included, but were not limited to: lorazepam (an antianxiety medication) concentrate; 2 mg(milligram)/mL(milliliter); 0.25 ml; oral at bedtime, dated 3/16/24. Discontinued physician orders included, but were not limited to: lorazepam 0.125mL (0.25mg) every 8 hours as needed, dated from 3/4/25 through 3/15/24. A current care plan related to receiving antianxiety medication included, but was not limited to, an intervention to administer medication per order, dated 3/8/24. Resident 29's Medication Administration Record (MAR) for 3/2024 indicated lorazepam 0.25mL was not administered on 3/16/24 due to "Drug/Item Unavailable", documented by Qualified Medication Aide (QMA) 17 on 3/16/24 at 10:32 P.M. The clinical record lacked progress notes on 3/16/24. On 3/27/24 at 12:20 P.M., a current Care Plan policy was provided, dated 12/31/23, and indicated "To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines ... Comprehensive care plans need to remain accurate and current"			

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F 0677 SS=E Bldg. 00	3.1-35(a) 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure Activities of Daily Living (ADLs) were provided for dependent residents for 4 of 4 residents reviewed for ADLs. Residents did not receive showers at least twice per week. (Resident 15, Resident 107, Resident 51, Resident 44) Findings include: 1. On 3/19/24 at 11:00 A.M., Resident 15 was observed with greasy, unbrushed hair. On 3/21/24 at 10:17 A.M., Resident 15 was observed sitting in the common area with greasy, unbrushed hair. On 3/25/24 at 9:22 A.M., Resident 15 was observed sitting in the common area with unbrushed hair. On 3/21/24 at 11:24 A.M., Resident 15's clinical record was reviewed. Diagnosis included, but were not limited to, dementia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 1/12/24, indicated cognitive status unable to be assessed, and no refusals or rejection of care. Resident 15's clinical record lacked care plans and/or current physician orders related to	F 0677	1. Residents # 15, # 107, # 51, and # 44 suffered no ill effects by the alleged deficient practice. Resident #107 discharged home from facility. Residents 15, 51, and 44 received showers and have been documented in medical records. Clinical staff were immediately educated on appropriate documentation of complete shower and/or bed bath in the electronic record. 2. All residents have the potential to be affected. Nursing staff to be educated on providing assistance with bathing activity of daily living with appropriate documentation in electronic record. 3. As a measure of ongoing compliance, the DHS or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, then monthly for 3 months to ensure bathing activity is completed and documented appropriately in the electronic record. 4. As a quality measure, the DHS or designee will review any findings and corrective action at	04/19/2024

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	providing assistance for showers or rejection of care. Resident 15's progress notes lacked refusals of showers or rejection of care. Resident 15's clinical record included the following related to bathing from 2/1/24 through 3/21/24: Showers: 2/7/24 2/9/24 2/12/24 2/17/24 2/21/24 2/29/24 3/2/24 3/9/24 3/16/24 3/20/24 Bed Baths: 2/2/24 2/10/24 2/28/24 On 3/21/24 at 11:22 A.M., a shower schedule was provided and indicated Resident 15 received showers on Wednesday and Saturday (day shift). On 3/21/24 at 10:39 A.M., CNA 45 indicated Resident 15 required a total assist of staff for bathing, and did not refuse showers. 2. On 3/19/24 at 11:06 A.M., Resident 107 was observed sitting in her room in a recliner with greasy hair. On 3/21/24 at 1:43 P.M., Resident 107's clinical record was reviewed. Admission date was 3/8/24.		least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	Diagnosis included, but were not limited to, dementia, anxiety, and depression. The most recent Admission MDS Assessment, dated 3/11/24, indicated no cognitive impairment, and no refusals or rejection of care. Resident 107's clinical record lacked care plans and/or current physician orders related to providing assistance for showers or rejection of care. Resident 107's progress notes lacked refusals of showers or rejection of care. Resident 107's clinical record included the following related to bathing from 2/1/24 through 3/21/24: Shower on 3/11/24 "other bath" On 3/21/24 at 11:22 A.M., a shower schedule was provided that indicated Resident 107 received showers on Tuesday and Fridays (day shift). On 3/21/24 at 10:39 A.M., CNA 45 indicated she was unsure whether Resident 107 was resistant to taking showers, because she had not been working on that hall when the resident needed one. At that time, the Assistant Director of Nursing (ADON) indicated Resident 107 was good about taking showers and did not refuse. 3. On 3/19/24 at 11:03 A.M., Resident 51 was observed lying in bed. A strong body odor was in the room. On 3/21/24 at 2:40 P.M., Resident 51's clinical record was reviewed. Admission date was 2/22/24. Diagnosis included, but were not limited to, Alzheimer's disease, anxiety, and depression.			

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	The most recent Admission MDS Assessment, dated 2/29/24, indicated a severe cognitive impairment, and no refusals or rejection of care. Resident 51's clinical record lacked care plans and/or current physician orders related to providing assistance for showers or rejection of care. Resident 51's progress notes lacked refusals of showers or rejection of care. Resident 51's clinical record included the following related to bathing from 2/1/24 through 3/21/24: Showers: 2/27/24 3/6/24 3/15/24 On 3/21/24 at 11:22 A.M., a shower schedule sheet was provided and did not list Resident 51. On 3/21/24 at 10:39 A.M., CNA 45 indicated Resident 51 was a total assist of staff with bathing, and took two showers per week. 4. On 3/19/24 at 11:00 A.M., Resident 44 was observed with greasy hair. On 3/21/24 at 10:18 A.M., Resident 44 was observed sitting in a chair in the common area with greasy hair. On 3/21/24 at 11:52 A.M., Resident 44's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, and depression. The most recent Quarterly MDS Assessment, dated 3/7/24, indicated a severe cognitive impairment, and no refusals or rejection			

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	of care. Resident 44's clinical record lacked care plans and/or current physician orders related to providing assistance for showers or rejection of care. Resident 44's progress notes lacked refusals of showers or rejection of care from 2/1/24 through 3/21/24. Resident 44's clinical record included the following related to bathing from 2/1/24 through 3/21/24: Showers: 2/27/24 Bed Baths: 2/1/24 2/23/24 Refusals: 2/6/24 2/13/24 3/19/24 On 3/21/24 at 11:22 A.M., a shower schedule was provided that indicated Resident 44 received showers on Tuesday and Fridays (day shift). On 3/21/24 at 10:39 A.M., CNA 45 indicated Resident 44 would sometimes refuse bathing, and when that happens, staff should attempt again later. She indicated anytime a resident refuses bathing, staff should document the refusal. On 3/25/24 at 2:45 P.M., QMA 39 indicated following a shower, staff were supposed to fill out a skin assessment and give that form to the nurse,			

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	then document the bathing in the resident's clinical record. She indicated at that time that Resident 44 required limited assistance of staff for bathing with a lot of cueing. On 3/25/24 at 11:53 A.M., the Director of Nursing (DON) provided a current Nursing ADL Documentation Guidelines policy, dated 12/31/23, that indicated "Completion of ADL services will be validated through the use of the CARE ASSIST ADL reports. This will be accomplished by the (DON) or designee. The CARE ASSIST Compliance Report will be reviewed and utilized during the morning stand-up interdisciplinary team meeting to review provision of services ... ADL services will be conducted and documented by the CNA each shift at the "point of care" or as reasonably possible after care. Access the CARE ASSIST Kiosk tap button "ADL" 3.1-38(a)(3)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to maintain safe and secure storage of medications for 1 of 2 medication carts observed. Loose pills were observed in the medication cart. (300 Hall) Findings include: On 3/26/24 at 10:31 A.M., the 300 Hall medication cart was observed with the following loose pills in the drawers: 1 round yellow pill 1 round white pill marked with HH210 on the pill 2 oblong white tablets marked with L484 on the pill 1 round pink pill marked with L21 on the pill 1 round light yellow pill During an interview on 3/26/24 at 10:37 A.M., QMA (Qualified Medication Aide) 23 indicated all nursing staff was responsible to clean out medication carts every other day and loose pills should be disposed of. During an interview on 3/27/24 at 10:26 A.M., the IP (Infection Preventionist) indicated there should not be loose pills in the med cart. On 3/27/24 at 12:20 P.M., the Administrator	F 0761	1. No residents were affected by this alleged deficient practice. 300 hall medication cart has been cleaned of loose pills. Licensed nursing staff were immediately educated on checking for and discarding loose pills from mediation carts. 2. All residents have the potential to be affected. Licensed nursing staff to be educated on ensuring loose pills are removed from the drawers of the medication carts. 3. As a measure of ongoing compliance, the DHS or designee will audit 5 random medication carts weekly x4 weeks, then every other week x2 months, then monthly x3 months to ensure the carts are free of loose pills. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as	04/20/2024

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	provided a Medication Storage in the Facility policy, revised 11/18 that indicated, "...contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal..." 3.1-25(m)		warranted.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:			

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	(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of			

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	its IPCP and update their program, as necessary. Based on observation and interview, the facility failed to ensure infection control practices were in place for 1 of 1 residents observed for insulin administration, and 1 of 1 random observation. Staff handled medications with bare hands prior to administering them to a resident, and staff placed an insulin syringe on the sink and an insulin supply case on a resident's catheter bag prior to administration of insulin. (Resident 107, Resident 43) Findings include: 1. On 3/19/24 at 11:14 A.M., Registered Nurse (RN) 3 was observed to prepare medications for administration. RN 3 removed medication cards from the medication cart, popped the pills into her bare other hand, then placed them into a medication cup. RN 3 was then observed to administer the medications to Resident 107. 2. On 3/25/24 at 10:22 A.M., Qualified Medication Aide (QMA) 5 was observed to administer insulin to Resident 43. QMA 5 entered the room, and placed the insulin supply box on top of the resident's catheter bag which was lying on top of his leg at the foot of the bed. QMA 5 then went into the bathroom, placed the insulin syringe containing the insulin onto the sink, and washed her hands. QMA put on a pair of gloves, picked up the syringe from the back of the sink, and administered the insulin to the resident. On 3/27/24 at 10:26 A.M., the Infection Preventionist (IP) indicated when retrieving medications from the medication cart, staff should put them directly into the medication cup, and not touch them with bare hands. At that time, he	F 0880	1. Residents # 107 and 43 suffered no ill effects from the alleged deficient practice. Residents were assessed with no concerns. Licensed nursing staff were immediately educated on proper infection control procedures during medication administration and insulin and storage of glucometer supply box use. 2. All residents have the potential to be affected. Licensed nursing staff to be educated on proper infection control procedures during medication administration. Licensed nursing staff to be educated on storage and placement of insulin syringe and glucometer supply box. 3. As a measure of ongoing compliance, the DHS or designee will audit 5 random medication passes for proper infection control procedures weekly x4 weeks, then every other week x2 months, then monthly x3 months. The DHS or designee will audit 3 random residents for proper infection control procedures during blood glucose checks weekly x4 weeks, then every other week x2 months, then monthly x3 months 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus	04/19/2024

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	indicated if insulin supply containers were brought into the room, they should be placed on the bedside table, and place a paper towel or other protective layer between an insulin syringe and the surface where it was placed. On 3/27/24 at 12:20 P.M., a current medication administration policy, dated 12/31/23, was provided, and indicated staff should not handle medications with bare hands. At that time, a basic infection control policy was requested and not provided. 3.1-18(b)(2)		Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey with the Investigation of Complaint IN00429428. This visit was in conjunction with the Investigation of Complaint IN00430875. Survey dates: March 19, 20, 21, 25, 26, 27, 2024 Facility number: 013332 Residential Census: 30 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	The submission of this plan of correction does not indicate an admission by The Villages at Oak Ridge that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of The Villages at Oak Ridge. 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	

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			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.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility	R 0217	1 Residents # 5, 6, and 7	04/19/2024

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	failed to ensure residents had signed service plans for 3 of 7 residents' records reviewed. (Resident 5, Resident 6, Resident 3) Findings include: 1. During record review on 3/27/24 at 1:15 P.M., Resident 5 failed to have a signed service plan. 2. On 3/27/24 at 12:45 P.M., Resident 6's clinical record was reviewed. Diagnosis included, but were not limited to, vascular dementia. Resident 6's clinical record lacked a signed service plan. On 3/27/24 at 12:45 P.M., the Director of Nursing (DON) and Regional Support provided Resident 6's most recent service plan, dated 1/10/24. The form was not signed. 3. On 3/27/24 at 1:20 P.M., Resident 3's clinical record was reviewed. Diagnosis included, but were not limited to, chronic kidney disease and heart disease. Resident 3's clinical record lacked a signed service plan. On 3/27/24 at 3:04 P.M., a current Service Plan policy, dated 12/31/23, was provided and indicated "A service plan shall be identified and implemented in response to the resident's evaluation and in collaboration with the resident and/or responsible party"		suffered no ill effects from the alleged deficient practice. -- -Residents # 5, 6, and 7 service plans have been signed. 2 All residents have the potential to be affected. Clinical leadership to be educated on proper completion with resident or responsible party signatures for the service plans. 3 As a measure of ongoing compliance, the DHS or designee will audit 3 random residents' service plans weekly x4 weeks, then every other week x2 months, then monthly x3 months to ensure completed with resident or responsible party signature. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or			

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	physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure prior authorization was obtained from a licensed nurse prior to medications administered by a Qualified Medication Aide (QMA) for 3 of 7 records reviewed. As needed (prn) medications were administered to residents by QMAs without documentation that a prior authorization was obtained. (Resident 6, Resident 5, Resident 4) Findings include: 1. On 3/27/24 at 12:45 P.M., Resident 6's clinical record was reviewed. Diagnosis included, but were not limited to, vascular dementia. Admission date was 12/8/22. Current physician orders included, but were not limited to: hydrocodone-acetaminophen 5-325mg (milligram) twice a day prn, dated 2/4/24. acetaminophen extended release tablet 650mg three times a day prn, dated 4/28/23. Resident 6's Medication Administration Record (MAR) from 2/2024 through 4/2024 indicated the following dates that hydrocodone-acetaminophen was administered by a QMA without prior authorization: 2/4/24 at 1:26 P.M. 2/11/24 at 11:31 A.M. and 11:42 P.M. 2/13/24 at 8:36 A.M.	R 0246	1 Residents # 6, 5, and 4 suffered no ill effects from the alleged deficient practice. ---Licensed nursing staff immediately educated on obtaining prior authorization when Qualified Medication aid (QMA) administers a PRN medication. 2 All residents have the potential to be affected. Licensed clinical staff to be educated on appropriate authorization for administration of a PRN medication. 3 As a measure of ongoing compliance, the DHS or designee will audit 3 random residents for appropriate authorization for administering a PRN medication weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	04/19/2024

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	2/15/24 at 6:24 P.M. 2/17/24 at 7:20 P.M. 2/18/24 at 7:02 A.M. 2/20/24 at 6:36 A.M. 3/9/24 at 11:41 A.M. Resident 6's Medication Administration Record (MAR) from 2/2024 through 4/2024 indicated the following dates that acetaminophen was administered by a QMA without prior authorization: 2/3/24 at 4:37 A.M. 2/8/24 at 6:17 A.M. 2/10/24 at 6:25 A.M. 2/11/24 at 11:17 A.M. 2/26/24 at 8:56 A.M. 3/16/24 at 7:14 A.M. 3/20/24 at 6:33 A.M. 2. During record review on 3/27/24 at 1:15 P.M., Resident 5's diagnosis included, but were not limited to, cerebral ischemia, and Alzheimer's disease with late onset. Resident 5's physician orders included, but were not limited to, acetaminophen tablet 500 mg (milligrams), amount: 1000 mg; oral Special instructions: Pain Every 6 hours prn (as needed), dated 8/11/23. A review of Resident 5's Medication Administration Record (MAR) from 1/1/24 thru 1/31/24, indicated acetaminophen 1000 mg was administered on 1/14/24 at 8:03 A.M. by QMA 5 without documentation of prior approval by a licensed nurse. Acetaminophen 1000 mg was administered on 1/21/24 at 1:36 P.M. by QMA 23 without documentation of prior approval by a licensed nurse. Acetaminophen 1000 mg was administered on 1/21/24 at 7:33 P.M. by QMA 35 without documentation of prior approval by a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155837	A. BUILDING 00 B. WING	03/27/2024

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	licensed nurse. 3. During record review on 3/27/24 at 2:04 P.M., Resident 4's diagnosis included, but were not limited to, syncope and collapse, unspecified fall, and occlusion and stenosis of bilateral carotid arteries. Resident 4's physician orders included, but were not limited to, Tylenol (acetaminophen) tablet; 325 mg; Amount to administer: 2 tablets; oral Every 6 hours prn Give as needed for pain, dated 4/16/23 A review of Resident 4's MAR from 2/1/24 thru 2/29/24, indicated Tylenol 325 mg, 2 tablets, were administered by QMA 37 on 2/12/24 at 3:48 A.M. without documentation of prior approval by a licensed nurse. On 3/27/24 at 2:20 P.M., the Regional Support indicated QMAs were required to obtain prior approval before giving prn medications. The approval should then be documented in the clinical record. On 3/27/24 at 3:04 P.M., Regional Support provided an Administration of PRN Medications Policy, dated 5/10/16, which indicated "...4. If PRN medication is to be administered by a QMA (Qualified Medication Aide) the Standards of Practice for PRN, medication administration by a Qualified Medication Assistant shall be observed under the direction of licensed nurse..."			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the			

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	resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to provide a statement that the residents show no evidence of tuberculosis in an infectious stage upon admission and yearly thereafter. (Resident 5, Resident 6, Resident 7) Findings include: 1. On 3/27/24 at 11:17 A.M., Resident 7's clinical record was reviewed. Resident 7's clinical record lacked an annual health statement.2. During record review on 3/27/24 at 1:15 P.M., Resident 5 failed to have an Annual Health Statement. 3. On 3/27/24 at 12:45 P.M., Resident 6's clinical record was reviewed. Diagnosis included, but were not limited to, vascular dementia. Admission date was 12/8/22. Resident 6's clinical record lacked an annual health statement. On 3/27/24 at 2:20 P.M., the Regional Support indicated she was unable to find annual health statements for Resident 5, Resident 6, or Resident 7, and that it should be in the physician orders. On 3/27/24 at 3:15 P.M., the Regional Support indicated the facility's policy for annual health statements was to follow the regulation.	R 0409	1 Residents # 5, 6, and 7 suffered no ill effects from the alleged deficient practice. Health statements have been entered for residents # 5, 6, and 7. 2 All residents have the potential to be affected. Licensed nurses to be educated on admission order set to include the admission statement showing free of communicable diseases including TB for new admissions and readmissions. Campus-wide in-house resident records audited and updated to ensure admission statement showing free of communicable disease including TB. 3 As a measure of on-going compliance, the DHS or designee will audit 3 new admissions weekly as applicable to ensure admission statement showing free of communicable disease including TB is added to medical resident. Audits will be weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as	04/19/2024

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			warranted.	