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	07/19/2023

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 the Investigation of Nursing Home Complaint IN00405855. This visit included the Investigation of Residential Complaint IN00405855. Complaint IN00405855 - Federal/state deficiencies related to the allegations are cited at F9999, F689, F761 Survey dates: July 18, 19, 2023 Facility number: 013332 Provider number: 155837 AIM number: 201305040 Census Bed Type: SNF/NF: 32 SNF: 16 Residential: 30 Total: 78 Census Payor Type: Medicare: 9 Medicaid: 26 Other: 13 Total: 48 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 21, 2023.	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 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Farris	RN, Clinical Support	08/03/2023

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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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure resident environments remained free of accident hazards in 2 of 4 halls observed. A treatment cart and two medication carts were observed unlocked. (Legacy Lane, 200 Hall) Findings include: 1. On 7/18/23 at 9:15 A.M., upon entrance to the facility, two medication carts were observed unlocked sitting by the Work Room across the hall from the nurse's station at the beginning of the 200 Hall. There were no staff observed at that time around the medication carts, and Qualified Nurse Aide (QMA) 3 was observed at the other end of the facility, near the 300 Hall speaking with another staff member. The medication carts were continuously observed until 9:23 A.M. During that time, Resident H was observed to wheel self by the medication carts in a wheelchair, then the Minimum Data Set (MDS) Coordinator was observed to lock the medication cart on the right when walking past it. Several staff members were observed to gather at the nurse's station as Scheduler 5 was interviewed. At the conclusion of the interview at 9:23 A.M., the medication cart on the left was observed locked. 2. During a continuous observation on 7/18/23 from 9:42 A.M. until 10:13 A.M., the health center locked unit (Legacy Lane), a treatment cart at the end of the hall was observed to be unlocked.	F 0689	. No residents were affected by the alleged deficient practice. Licensed nursing staff were immediately educated on locking the medication and treatments carts when left unattended. 2. All residents have the potential to be affected. Licensed nursing staff to be educated on ensuring medication and treatment carts are locked when left unattended. 3. As a measure of ongoing compliance, the DHS or designee will complete random cart audits 3x's weekly x4 weeks, then 3x's weekly every other week x4 weeks, then monthly x4 months to ensure medication carts are locked per policy. 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.	08/09/2023

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	Several times during the observation, no staff were observed in the hall. Resident J was observed to wander in the hall. At the end of the observation, QMA 7 indicated the treatment cart had been left unlocked by the wound nurse that morning, and usually did not pay attention to that cart, as she did not use it herself. At that time, QMA 7 did not lock the treatment cart. On 7/18/23 at 10:50 A.M., Registered Nurse (RN) 9 indicated staff needed to be locking the treatment carts when not in use. At that time, she indicated the carts were usually left unlocked due to the treatment nurse not being able to locate the nurse or QMA that had the keys on the unit, but were supposed to be locked. At that time, RN 9 went onto the Legacy Lane unit, and the treatment cart was observed still unlocked. The cart included, but was not limited to, the following items: A bottle of Nystatin powder belonging to Resident K A tube of skin protectant cream (no name) with warning label "Keep out of reach of children" A tube of Voltaren cream (no name) with warning label "Keep out of reach of children" A tube of Desitin cream belonging to Resident L A tube of hemorrhoid cream belonging to Resident N (RN 9 indicated resident no longer on that unit) A tube of Desitin cream belonging to Resident M (RN 9 indicated resident passed away "a couple of days ago") A bottle of Biofreeze (no name) with warning label "Keep out of reach of children" A tube of Hydrocortisone cream belonging to Resident P A tube of Aspercreme belonging to Resident P A box of diclofenac sodium cream belonging to Resident Q with warning label "Keep out of reach of children"			

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	A bag of heparin lock syringes A tube of wound gel (no name) On 7/19/23 at 9:36 A.M., the Regional Consultant indicated medication and treatment carts should be kept locked. The only exception is if the nurse is within sight of the cart. On 7/19/23 at 10:18 A.M., a current Medication Storage policy, revised 11/18, was provided and indicated "Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access" This Federal tag relates to Complaint IN00405855. 3.1-25(m) 3.1-45(a)(1)			
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. §483.45(h)(2) The facility must provide separately locked, permanently affixed			

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	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 ensure medications were disposed of properly for 1 of 1 medication disposal observed. An expired resident's medication was thrown in the trash container in a common area. (Resident M) Finding includes: On 7/18/23 at 11:02 A.M., Registered Nurse (RN) 9 was observed to obtain a tube of Desitin cream out of a treatment cart on the Legacy Lane locked unit. A label on the tube was observed with Resident M's name. At that time, RN 9 indicated Resident M had passed away "a couple of days ago". RN 9 took the tube to the common area where residents were seated around a table, and tossed it in the open top trash container by the nurse's desk. At that time, Qualified Nurse Aide (QMA) 7 was observed to take the tube of Desitin cream out of the trash, and mark out Resident M's name with a black marker before tossing it back into the same trash can. On 7/19/23 at 9:38 A.M., the Regional Consultant indicated when a resident passed away, any medications not opened should have been sent back to the pharmacy. All other medications (including creams) should have the label taken off and thrown away in an area that was not around residents. She indicated if staff was unsure about how to dispose of medications, they should	F 0761	1. No residents were affected by the alleged deficient practice. RN 9 and QMA 7 were immediately educated on proper disposal of medication. 2. All residents have the potential to be affected. Licensed nursing staff to be educated on proper disposal of medications. 3. As a measure of ongoing compliance: The DHS or designee will complete random audits 3x's weekly x4 weeks, then 3x's weekly every other week x4 weeks, then monthly x4 months to ensure proper medication disposal. 4. As a quality measure, the DHS or designee will review any findings and corrective action weekly in QAPI meetings until achieved compliance, then 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.	08/09/2023

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	consult the facility's policy. On 7/19/23 at 10:18 A.M., a current Disposal of Non-Controlled Drugs policy, revised 12/1/21, was provided and indicated "Medications that have been dropped, removed from the container in error, or otherwise requires disposal may be placed in the sharp's container or through an approved medication disposal method to ensure they are not obtainable to other residents" This Federal tag relates to Complaint IN00405855. 3.1-25(o)			
F 9999 Bldg. 00	ADMINISTRATION AND MANAGEMENT 3.1-13(w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia- specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both of	F 9999	1. No residents were affected by the deficient practice. The facility special care unit disclosure form designates the director for the Alzheimer's and dementia special care unit as the licensed health facility administrator. The badge stating Legacy Director was corrected to Legacy Lane Coordinator-LPN. 2. No residents have the potential to be affected. Education was provided to the leadership team on the requirements of the dementia care unit director. 3. As a measure of ongoing compliance, the ED or designee will audit to ensure the designated dementia care unit director meets the qualifications for 3x's weekly x4 weeks, then 3x's weekly every	08/09/2023

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	cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. This State Rule was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the Director of the Alzheimer's Unit had met the qualifications for the position for 1 of 1 employees identified as Director, and the job description did not address required educational experience as required by the State of Indiana. Findings include: On 7/18/23 at 9:42 A.M., CNA 7 indicated LPN 15 was the Dementia Coordinator for both locked units on skilled (100 unit) and AL(Assisted Living) (400 unit). On 7/18/23 at 1:38 P.M., the Division Vice President (DVP) indicated the previous Administrator took over on 6/8/23. She was here daily until last week when she was only here Monday and Tuesday. Now she was coming about one time a week while the interim Administrator was here day to day. The new Administrator was scheduled to start 8/1/23. Right now, the previous Administrator was listed as the Dementia Care Coordinator. On 7/18/23 at 2:16 P.M., LPN 15 indicated she was the Dementia Coordinator for both dementia units on skilled and AL. She indicated she had been the Director for 2 1/2 years on the 400 unit and took over both units in April (400 and 100 units). Her badge indicated she was "Legacy Director". On 7/19/23 at 9:52 A.M., a current Legacy Lane		other week x4 weeks, then monthly x4 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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	Coordinator job description was provided by the Interim Administrator, dated 12/7/18, which indicated the Coordinator reports to: Legacy Neighborhood Director/ Executive Director/ Director of Assisted Living and the duties and responsibilities included, but were not limited to, "...11. Maintains a dementia-safe environment through daily resident room and Lane rounds, management of noise and other environmental stimuli throughout the Lane..." At that time, the Regional Consultant indicated the Legacy Lane Coordinator job description was used as the policy, as there was no formal policy related to the dementia care coordinator. A signed Legacy Lane Coordinator job description was provided which was signed by LPN 15 on 12/7/20. On 7/19/23 at 10:30 A.M., LPN 15's employee record was reviewed and no degree information was located. On 7/19/23 at 12:10 P.M., the Regional Consultant indicated LPN 15 did not have any other degrees. On 7/19/23 at 12:30 P.M., the DVP indicated during the exit conference that LPN 15 was titled "Dementia Care Coordinator" and the Administrator was titled "Dementia Care Director" While LPN 15 oversaw the units, she reported to the Administrator who was the Director. This state finding relates to complaint IN00405855.			
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00405855. This visit included the Investigation of Nursing Home Complaint IN00405855.	R 0000	The submission of this plan of correction does not indicate an admission by The Villages at Oak Ridge that the findings and	

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	Complaint IN00405855- State deficiency related to the allegations are cited at R0095. Survey date: July 18, 19, 2023 Facility number: 013332 Residential Census: 30 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.		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.	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the			

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	past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on observation, interview, and record review, the facility failed to ensure the Director of the Alzheimer's Unit had met the qualifications for the position for 1 of 1 employees identified as Director, and the job description did not address required educational experience as required by the State of Indiana. Findings include: On 7/18/23 at 9:42 A.M., CNA 7 indicated LPN 15 was the dementia coordinator for both locked units on skilled (100 unit) and AL(Assisted Living) (400 unit). On 7/18/23 at 1:38 P.M., the Division Vice President (DVP) indicated the previous administrator took over on 6/8/23. She was here daily until last week when she was only here Monday and Tuesday. Now she was coming about one time a week while the interim administrator was here day to day. The new administrator started 8/1/23. Right now, the previous administrator was listed as the dementia care coordinator.	R 0095	1. No residents were affected by the deficient practice. The facility special care unit disclosure form designates the director for the Alzheimer's and dementia special care unit as the licensed health facility administrator. The badge stating Legacy Director was corrected to Legacy Lane Coordinator-LPN. 2. No residents have the potential to be affected. Education was provided to the leadership team on the requirements of the dementia care unit director. 3. As a measure of ongoing compliance, the ED or designee will audit to ensure the designated dementia care unit director meets the qualifications for 3x's weekly x4 weeks, then 3x's weekly every other week x4 weeks, then monthly x4 months. 4. As a quality measure, the	08/09/2023

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	On 7/18/23 at 2:16 P.M., LPN 15 indicated she was the dementia coordinator for both dementia units on skilled and AL. She indicated she had been the director for 2 1/2 years on the 400 unit and took over both units in April (400 and 100 units). Her badge indicated she was "Legacy director". On 7/19/23 at 9:52 A.M., a current Legacy Lane Coordinator job description was provided by the Interim Administrator, dated 12/7/18, which indicated the Coordinator reports to: Legacy Neighborhood Director/ Executive Director/ Director of Assisted Living and the duties and responsibilities included, but were not limited to, "...11. Maintains a dementia-safe environment through daily resident room and Lane rounds, management of noise and other environmental stimuli throughout the Lane..." At that time, the Regional Consultant indicated the Legacy Lane Coordinator job description was used as the policy, as there was no formal policy related to the dementia care coordinator. A signed Legacy Lane Coordinator job description was provided which was signed by LPN 15 on 12/7/20. On 7/19/23 at 10:30 A.M., LPN 15's employee record was reviewed and no degree information was located. On 7/19/23 at 12:10 P.M., the Regional Consultant indicated LPN 15 did not have any other degrees. On 7/19/23 at 12:30 P.M., the DVP indicated during the exit conference that LPN 15 was titled "dementia care coordinator" and the Administrator was titled "dementia care director" While LPN 15 oversaw the units, she reported to the administrator who was the director.		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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	This state residential finding relates to complaint IN00405855.			