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	04/02/2025

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VILLAGES AT OAK RIDGE, THE	1694 TROY ROAD WASHINGTON, IN 47501

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Nursing Home Complaints IN00456575 and IN00456619. This visit included a State Residential Licensure Survey. Complaint IN00456575 - Federal/State deficiencies related to the allegations are cited at F725 and F690. Complaint IN00446619 - Federal/State deficiencies related to the allegations are cited at F677 and F690. Survey dates: March 25, 26, 27, 28, 31, April 1, 2, 2025 Facility number: 013332 Provider number: 155837 AIM number: 24133321 Census Bed Type: SNF/NF: 32 SNF: 18 Residential: 30 Total: 80 Census Payor Type: Medicare: 11 Medicaid: 24 Other: 15 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 11, 2025.	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Wall	RN HFA	04/25/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to ensure residents requiring assistance with Activities of Daily Living (ADLs) received adequate assistance with bathing for 2 of 2 residents reviewed for ADL care. (Resident C, Resident J) Findings Include: 1. During an interview on 3/25/25 at 10:41 A.M., Resident J indicated she received showers once a week. On 4/01/25 at 10:57 A.M., Resident J's clinical record was reviewed. Diagnoses included, but was not limited to anemia, coronary artery disease, and depression. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 2/12/25 indicated Resident J had moderate cognitive impairment and required moderate assistance with bathing. A current care plan, initiated on 6/14/2022, was provided and indicated Resident J required staff assistance to complete ADL tasks completely and safely. Resident J's care plan lacked information on functional status related to bathing. On 4/2/25 at 10:00 A.M., Resident J's shower record from 1/1/25 to 4/2/25 was provided by the interim Director of Nursing (DON). Resident J failed to receive a shower from 1/3/25 to 1/14/25, 2/11/25 to 2/18/25, 2/25/25 to 3/4/25, and 3/18/25 to 3/25/25 with no refusals of care or leave of absence documented for that time period.	F 0677	1. Residents J and C suffered no ill effects by the alleged deficient practice. Residents J and C 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 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	05/01/2025

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	During an interview on 4/2/25 at 10:14 A.M., Certified Nurse Aide (CNA) 42 indicated Resident J should receive showers on Tuesdays and Fridays. 2. On 3/28/25 at 10:44 A.M., Resident C was observed sitting up in bed and the back of her hair was greasy. At that time she indicated she was not getting baths twice a week. She indicated she had not had a bath since last week and her hair had only been washed four times since her admission on 2/18/25. On 3/31/25 at 11:40 A.M., Resident C's clinical records were reviewed. Diagnoses included, but were not limited to, wedge compression fracture of T 9-T 10 vertebra, multiple fractures of ribs on right side, pulmonary embolism, Methicillin resistant Staphylococcus aureas infection, Escherichia coli (E. coli), open wound of anus, open wound of lower back and pelvis, and retention of urine. The current Admission Minimum Data Set (MDS) assessment, dated 2/21/25 indicated Resident C was cognitively intact, and was dependent on staff for shower/bath, toilet use, bed mobility, and transfers. Resident C's urinary continence was not rated because she had a catheter. It was very important for her to choose between a tub bath, shower, bed bath, or sponge bath. Resident C's impaired functional status related to decreased mobility care plan, dated 2/21/25, had an intervention which included, but was not limited to, provide assistance as needed with self-care and mobility functional tasks, dated 2/21/25. On 4/1/25 at 9:37 A.M., Resident C's Baths recorded was reviewed:			

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	3/31/25 Complete Bed Bath 3/28/25 Partial Bed Bath 3/18/25 Complete Bed Bath 3/7/25 Other bath 3/2/25 Complete Bed Bath 3/1/25 Complete Bed Bath 2/28/25 Complete Bed Bath 2/27/25 Not recorded 2/19/25 Partial Bed Bath There were no refusals documented. During an interview on 4/1/25 at 2:27 P.M., Certified Nurse Aide (CNA) 42 and CNA 28 indicated residents got a shower two to three times a week depending on their preference. They were put on a schedule and the CNAs followed the schedule for showers. If a resident was unable to go to the shower, they got a bed bath and it followed the shower schedule. The showers were documented on the shower sheet and in Matrix. On 4/2/25 at 10:57 A.M., the Interim Director of Nursing provided a Guideline for Bathing Preference policy, reviewed 12/17/24, which indicated "...4. Bathing shall occur at least twice a week unless resident preference states otherwise." This citation relates to Complaint IN00456619. 3.1-38(b)(2)			
F 0690 SS=E Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, and record review, the facility failed to ensure appropriate care and services were provided to prevent urinary tract infections for residents with urinary	F 0690	1. Residents B, E, D, and C were affected but suffered no ill effects from the alleged deficient practice. Residents were assessed with no	05/01/2025

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	catheters or were incontinent of bladder for 4 of 4 residents reviewed for incontinence/catheter care. (Resident B, Resident E, Resident D, Resident C) Findings include: 1. On 3/31/25 at 9:57 A.M., Resident B's clinical record was reviewed. Resident was admitted 3/13/25. Diagnosis included, but were not limited to, dementia and kidney failure. The most recent Admission Minimum Data Set (MDS) assessment, dated 3/17/25, indicated a severe cognitive impairment and no behaviors. Resident was dependent on staff for eating, toileting, and bathing. Resident frequently incontinent of bladder, and did not have a urinary catheter at admission. Physician orders included, but were not limited to: May dip urine with signs and symptoms of urinary tract infection (UTI), then may send urine for culture and sensitivity (C&S) if positive for leukocytes, dated 3/13/25. Indwelling urinary catheter size 16 with 10cc (milliliter) balloon, dated 3/19/25. cephalexin (an antibiotic) 250 mg (milligrams) twice a day, started 3/19/25 and completed 3/25/25. The order was signed by the physician on 3/20/25. Resident B had a current bowel and bladder care plan, dated 3/21/25, that indicated use of a urinary catheter. Resident B's progress notes included, but were not limited to, the following: 3/14/25 11:34 A.M. Resident had not voided since		concerns. Licensed staff and clinical leaders were immediately educated on urine culture follow-up for appropriate antibiotic treatment. Licensed staff and clinical leaders were immediately educated on following discharge instructions when entering medications. QMA (Qualified medication aide) and PTA (Physical therapy assistant) were immediately educated on appropriate infection control procedure during catheter care. Nursing staff were immediately educated on proper storage of urinary catheter bags when not in use. Nursing staff were immediately educated on appropriate urinary drainage bag placement. Nursing staff were immediately educated on catheter care procedures. 2. All like residents have the potential to be affected. Licensed nursing staff and clinical leaders to be educated on hospital discharge order(s) follow-up specifically urine cultures. Licensed nursing staff and clinical leaders to be educated on appropriate antibiotic use. Licensed nursing staff and clinical leaders to be educated on following discharge instructions when entering medications. Nursing staff to be educated on providing appropriate infection control practices during catheter care. Nursing staff to be educated on appropriate storage of urinary	

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	leaving the ER the previous day and abdomen was distended. The bedpan was offered multiple times, but resident unable to void. Three attempts were made to straight cath the resident with no output. Resident was able to void once taken to the toilet. 3/16/25 9:21 P.M. Resident indicated she didn't feel very good and was pale in color. Blood pressure 92/62, respirations 20, and oxygen saturation 95% on room air. Resident incontinent of bladder during shift. 3/19/25 9:35 A.M. Resident's abdomen was noted to be hard and distended with tenderness around 7:00 A.M. Resident was sent to the Emergency Room (ER). 3/19/25 3:21 P.M. Resident arrived back from the ER with a urinary catheter in place and an order for cephalexin (Keflex) 250mg twice daily for 7 days for UTI. 3/20/25 11:13 P.M. Hospital lab contacted facility and stated they would send over the urinalysis and C&S once it was completed. 3/27/25 1:17 A.M. Antibiotic completed 3/25/25 per order. Resident B's clinical record lacked a care plan for UTI from 3/19/25 through 3/25/25. Discharge paperwork from the ER visit on 3/19/25 lacked a C&S result and indicated to start the resident on a 7 day course of Keflex twice a day (14 doses total). Resident B's clinical record lacked a C&S result from the ER visit on 3/19/25, and lacked		catheter bags when not in use. Nursing staff to be educated on appropriate urinary drainage bag placement. 3. As a measure of ongoing compliance: The DHS or designee will ensure cultures have been received, reviewed and MD notification completed as warranted during CCM (clinical care meeting), 5x weekly x 2 months, then 3x weekly x2 months, then weekly x2 months. The DHS or designee will audit 5 antibiotic orders, as warranted, to ensure appropriate treatment with appropriate diagnosis: weekly x2 months, then every other week x2 months, then monthly x2 months. The DHS or designee will audit 5 admissions or readmissions, as warranted to ensure discharge instructions are followed when entering medications. Audits will be conducted weekly x2 months, then every other week x2 months, then monthly x2 months. The DHS or designee will audit to ensure appropriate infection control practices during catheter care are followed per policy on 5 residents weekly x2 months, then every other week x2 months, then monthly x2 months. The DHS or designee will audit like residents to ensure urinary catheter bags are stored appropriately when not in use 5x weekly x2 months, then 3x weekly	

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	communication with the physician related to C&S results. On 4/1/25 at 2:04 P.M., Resident B's C&S result was obtained from the hospital and reviewed. The culture report indicated it was resulted 3/21/25 and showed pseudomonas aeruginosa as the bacteria that caused the UTI. The C&S was resulted the day after the physician signed the Keflex order for Resident B. The research article "Antibiotic susceptibility patterns of Pseudomonas aeruginosa at a tertiary care hospital in Gujarat, India", dated October 2008, was retrieved on 4/1/25 from the Bioline International website at https://www.bioline.org.br/pdf?ph08065. The article included: "The organism [pseudomonas aeruginosa] showed remarkable resistance against cephalosporin group of antibiotics, ranging from 67.86% for ceftazidime to 94.64% for cephalexin [Keflex]" Resident B's Medication Administration Record (MAR) from March 2025 indicated Keflex was administered once on 3/19/25 and twice daily for the following six days, totaling 13 doses given. On 4/1/25 at 9:49 A.M., Qualified Medication Aide (QMA) 14 and Physical Therapy Assistant (PTA) 32 were observed to assist Resident B with toileting and catheter care. After assisting the resident to stand (resident had a bowel movement while sitting on the toilet), QMA 14 cleaned the resident's peri area from the back, then cleaned the area from the front. After wiping a brown substance from the vaginal area several times, QMA 14 wiped the catheter tube from the bottom up one time, then wiped more brown substance from the vaginal area. PTA 32 then placed the		x2 months, then weekly x2 months. The DHS or designee will audit like residents to ensure appropriate placement of urinary drainage bag. Audit will be conducted 5x weekly x2 months, then 3x weekly x2 months, then weekly x2 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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	resident's catheter bag on the bathroom floor before handing it to QMA 14. Without changing gloves or performing hand hygiene, QMA 14 assisted to get Resident B dressed and to the wheelchair. Again without changing gloves or performing hand hygiene, QMA 14 then obtained a graduated cylinder from the bathroom, placed it on the floor by the resident's wheelchair, and emptied the urine from the catheter bag into it. After emptying the urine, QMA removed the gloves and performed hand hygiene. On 4/1/25 at 2:45 P.M., the Infection Preventionist (IP) indicated when a resident returned from the hospital on an antibiotic, management would look through their hospital records and log that information. He indicated the facility would follow any orders placed from the ER physician and either the facility Nurse Practitioner or physician would review the orders. At that time, the Interim Director of Nursing (DON) indicated if the facility physician was ordering an antibiotic, they would be looking at the culture. On 4/2/25 at 11:18 A.M., the IP indicated Resident B should have received a full 14 doses of Keflex after returning from the ER on 3/19/25. On 4/2/25 at 11:46 A.M., the Interim DON indicated the C&S result was sent to a primary care, and it was thought that it was sent to a different primary care listed and did not go to the facility physician. 2. On 3/25/25 at 10:41 A.M., Resident E was observed sitting in the recliner in her room with her legs elevated. At that time, the resident indicated she was recovering from being in the hospital for a urinary tract infection (UTI). She indicated she had a tube (suprapubic catheter) that went into her bladder and she wore a bag on			

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	the top of her leg during the day and staff would change the leg bag to the other bag that's kept in the bathroom at night. There was a urinary catheter bag observed in the resident's private bathroom, uncovered, hanging on the handrail with a yellow liquid and sediment in the tubing. On 3/31/25 at 2:32 P.M., Resident E was observed sitting in the recliner in her room with her legs elevated and she indicated she was wearing her leg bag. There was a urinary catheter bag with yellow liquid and sediment in the tubing in a bag that was not enclosed laying on her wheelchair observed in her private bathroom. On 4/1/25 at 11:33 A.M., there was a urinary catheter bag observed in a plastic bag tied to the handrail behind the toilet in bathroom but not completely enclosed. The tube has sediment and yellow liquid in it. Resident E was sleeping in a reclined position. She indicated she was wearing her leg bag on top of her leg and she did not remember staff educating her on the increased risk of getting a UTI from the leg bag being above her bladder. On 3/28/25 at 1:19 P.M., Resident E's clinical record was reviewed. Diagnoses included, but are not limited to, heart failure, hematuria (blood in her urine), personal history of UTIs, pyleonephrosis (kidney infection), nephrolithiasis (kidney stones), and obstruction and reflux of urine in the urinary tract. The most recent Quarterly MDS assessment, dated 2/14/25, indicated Resident E was cognitively intact, substantial/maximum assist (staff performs over half the effort) for toileting, showering, transfers, has an indwelling catheter, and had sepsis and UTI in the last 30 days.			

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Current Physician's Orders included, but were not limited to, the following:
change catheter bag as needed based on clinical indications such as infection, obstruction, or when the closed system was compromised, ordered 2/9/25
suprapubic catheter (SP) care every shift, clean with normal saline apply neosporin and lidocaine to SP site, and apply new split sponge, ordered 3/28/25
SP catheter size 18 French with 30 cc balloon for obstructive uropathy, ordered 2/11/25

A current SP Catheter Care Plan, initiated 12/19/23 and last reviewed on 3/27/25, included, but was not limited to, the following intervention:
maintain a closed system with drainage bag below the resident's bladder and cover with dignity bag, initiated 12/19/23

A Hospital Discharge Summary, dated 2/8/25, indicated "Hospital Course: Patient came via EMS [Emergency Medical Services] from [name of facility] due to hematuria from suprapubic catheter. She was found to have septic shock, 2/2 GNR bacteremia [2 of 2 blood cultures growing gram negative rod bacteria-proteus, urinary source] and left hydronephrosis [enlarged kidney] with bilateral nephrolithiasis [kidney stones in both kidneys].

The article, "Proteus mirabilis [P. mirabilis] and Urinary Tract Infections," dated 11/5/15, was retrieved on 4/3/25, from the National Library of Medicine website at https://pmc.ncbi.nlm.nih.gov/. The guidance included: "Proteus species, including P. mirabilis, are part of the normal flora of the human gastrointestinal tract, along with other bacteria

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	like Escherichia coli and Klebsiella. Infections can also arise from contaminated urinary catheters, which can introduce the bacteria into the urinary tract. Long-term catheterization is a significant risk factor for P. mirabilis UTIs. Proteus mirabilis is capable of causing symptomatic infections of the urinary tract including cystitis and pyelonephritis and is present in cases of asymptomatic bacteriuria, particularly in the elderly and patients with type 2 diabetes. These infections can also cause bacteremia and progress to potentially life-threatening urosepsis. Additionally, P. mirabilis infections can cause the formation of urinary stones (urolithiasis). P. mirabilis is often isolated from the gastrointestinal tract, although whether it is a commensal, a pathogen, or a transient organism, is somewhat controversial. It is thought that the majority of P. mirabilis urinary tract infections result from ascension of bacteria from the gastrointestinal tract while others are due to person-to-person transmission, particularly in healthcare settings." During an interview on 4/1/25 at 10:45 A.M., Licensed Practical Nurse (LPN) 5 indicated only nurse's do catheter dressing care. Certified Nurse Aides (CNAs) could cleanse the area with perineal care or bathing if needed, empty and change the urinary catheter bags, and would notify the nurse if urine was dark, SP site or urine had foul odor, or the resident was not having normal urine output. There were CNAs who did not like connecting and disconnecting the catheter bags so she would do it most of the time when she was working. She had no concerns about the catheter tubing being compromised by urine and sediment sitting in the tube and being able to drain backwards into the bag while the bag was not in use, the end not being capped, or not covering the bag completely			

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	in the bathroom while the resident wasn't wearing it. The urologist does not want the facility to change the SP catheter tube. They were allowed to flush it and if that didn't help then they had to call him and he usually sent the resident to the Emergency Room (ER) and have the SP catheter tubes changed at the hospital. All catheters were secured in place to the resident's leg. Resident E had a history of UTIs and preferred a leg drainage bag placed on top of her leg during the day. Resident E's urologist was aware the resident's preference was to wear the leg bag on top of her leg while she sat in her recliner with her legs elevated during the day. There should be documentation in the record that the urologist was aware of it and that the resident had been educated on the potential increased risk of UTIs wearing it that way. The urinary catheter bags should be kept in an enclosed bag and the end capped. If the tubing or the catheter bag was compromised, they would replace it, otherwise at least every 30 days (usually when she went to the urologist) the staff would change the bag. During an interview on 4/1/25 at 3:44 P.M., the Regional Consultant indicated there was not documentation of Resident E's preference or that she was educated about having the catheter bag below her bladder and knowing the increased risk of UTIs from the way she was wearing it and changing the bags back and forth every morning and night in her clinical record. 3. On 3/28/25 at 1:18 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, retention of urine, dementia, and Type II diabetes mellitus with hyperglycemia. The most recent Admission MDS assessment, dated 2/26/25, indicated Resident D had moderate cognitive impairment, was dependent of staff for			

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	shower/bath, toilet use, bed mobility, and transfers and had a catheter. Current Physician orders included, but were not limited to, the following: Foley catheter care every shift Twice A Day, 6:00 A.M. - 6:00 P.M., 6:00 PM - 6:00 A.M., dated 2/27/25 A current Foley Catheter Care Plan, initiated on 2/28/25, included, but was not limited to, the following interventions: Leg strap in place to prevent residents catheter from being pulling out, initiated 2/28/25 Maintain a closed system with urinary bag below the residents bladder and cover, initiated 2/28/25 Provide assist with catheter care and change Foley catheter per physician orders, initiated 2/28/25 Observe for any signs of complication such as UTI, urethral trauma, strictures, bladder calculi or silent hydronephrosis notify my doctor, initiated 2/28/25 Urology Notes from 3/24/24: Insertion Foley catheter, indwelling Procedure note: Patient placed in supine position. 10 cc used to deflate balloon, 30 cc in all. Noticed redness on left thigh and purulent drainage coming from penile area. (name of Nurse Practitioner) notified and came in and placed catheter a 16 Fr (French) coude catheter (size and type of catheter). No resistance met. Catheter looped and secured with stat lock. Had a larger area that catheter eroded meatus and meatus was not in the correct area. Gave report to LPN 38 at (name of facility). Instructed that there was a large			

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	place of erosion in penile area. Area needs to be closely watched, patient needs good catheter care, stat lock needs to stay on, and catheter needs to be looped. Assessment and plan: Erosion on urethral meatus as well as yeast infection on thighs and penis Orders: Nursing home may put Neosporin ointment (antibiotic ointment) on tip of penis to alleviate discomfort please keep Foley catheter in stat lock device please retract foreskin and clean glans twice daily, then apply Nystatin ointment twice daily to foreskin and thighs Progress Notes: 3/28/2025 3:07 P.M. "Family called and spoke the ED [Executive Director] about concerns over resident's catheter. ED and DHS [Director of Health Services/DON] are conferencing with the family to further address concerns. Family was thinking about taking resident back to the [name of facility] today. Resident was an anticipated discharge for 4/3/25 and the [name of facility] did come in to evaluate resident on 3/27/25 and they did accept resident back." 3/28/2025 3:49 P.M. Medical Director contacted to give orders to discharge resident back to (name of facility). Following a call from (resident's family members) about concerns, and they were insistent that resident discharge today. Orders received, clinical support and DON aware and addressing concerns. Progress notes did not mention any skin issues related to penile area or redness on leg.			

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	During an interview on 3/31/25 1:29 P.M., Resident D's family member indicated the catheter had not been taken care of and Resident D had an appointment with urologist on 3/24/25 when abscess on the head of his penis was discovered. During an interview on 4/1/25 at 9:10 A.M., Resident D's family member indicated the Nurse Practitioner) NP at the Urology Office examined him at an appointment on 3/24/25 and made comments about the shape of the catheter. She said it had not been cleaned or properly strapped to his leg and caused damage to his urethra and caused an abscess on his penis under his foreskin. The family member indicated Resident D saw a surgeon on 3/31/25 for the damage and he was in a lot of pain. 4. On 4/1/25 at 10:54 A.M., Resident C was observed lying in bed with head of the bed elevated, Foley catheter draining yellow urine hanging on the side of the bed covered, and wound vac in place to coccyx wound. At that time, she indicated the catheter care was not not done routinely on a daily basis, only if she had an accident or was given a bath. On 3/31/25 at 11:40 A.M., Resident C's clinical records were reviewed. Diagnoses included, but were not limited to, wedge compression fracture of T9-T10 vertebra, multiple fractures of ribs on right side, pulmonary embolism, Methicillin resistant Staphylococcus aureas infection, Escherichia coli (E. coli), open wound of anus, open wound of lower back and pelvis, and retention of urine. The most recent Admission MDS assessment, dated 2/21/25 indicated Resident C was cognitively intact, and was dependent on staff for			

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	shower/bath, toilet use, bed mobility, and transfers. Resident C's urinary continence was not rated because she had a catheter. Current Physician orders included, but were not limited to, the following: Foley catheter care every shift Twice A Day 6:00 P.M. - 6:00 A.M., 06:00 A.M. - 06:00 P.M., dated 2/19/25 A current Foley Catheter Care Plan, initiated on 3/3/25, included, but was not limited to, the following interventions: Provide assist with catheter care and change Foley catheter per physician orders, initiated 3/3/25 Maintain a closed system with urinary bag below the residents bladder and cover, initiated 3/3/25 Observe tubing and avoid any obstructions, initiated 3/3/25 Observe for any signs of complication such as UTI (urinary tract infection), urethral trauma, strictures, bladder calculi or silent hydronephrosis notify my doctor, initiated 3/3/25 During an interview on 4/2/25 at 9:22 A.M. Resident D indicated she did not get catheter care on evenings or nights the day before. She indicated the only time she got catheter care was when she had an accident and when they gave her a bath. CNAs cleaned the back side and a few CNAs would clean the front, but sometimes she had to ask them to clean the front. During an interview on 4/1/25 at 10:45 A.M., LPN 5 indicated anyone with a catheter was on EBP (Enhanced Barrier Precautions), gown and gloves,			

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	when doing care. Catheter care was done with perineal care. All catheters were secured in place to the resident's leg. LPN 5 indicated catheter care was the same whether the resident was male or female. Care was started on inside and worked your way out, then down tube (going away from the insertion site), monitor for foul odor, drainage, amount and color of output. The nurse was notified if anything unusual was found and nurse would assess. If a resident had foreskin, you pulled down the foreskin, wiped, and when done you put the foreskin back up. Nurses and nurse aides had inservices on catheter care and everything to do with it monthly. During an interview on 4/1/25 at 11:11 A.M., CNA 23 indicated catheter care was done three times a day on each shift by the CNAs. During an interview on 4/1/25 at 1:15 P.M., the Interim DON provided the most recent in service given on 3/25/25 and 3/26/25 to nursing staff on suprapubic catheter care, urinary catheter care, and perineal care for incontinence. On 3/25/25 at 11:00 A.M., the Administer provided a current Antibiotic Stewardship Guideline Policy, dated 12/31/22, that indicated "New orders for antibiotic usage will be reviewed during the campus Clinical Care Meeting on regular business days including antibiotics on new admissions from the community" On 4/1/25 at 1:15 P.M., the Interim DON provided a current Perineal Care for Incontinence policy, dated 12/16/24, that indicated "Pay particular attention to infection prevention and control techniques when performing pericare, to prevent introduction of contamination that may lead to a urinary tract infection"			

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	On 4/1/25 at 1:15 P.M., the Interim Director of Nursing provided a Urinary Catheter Care policy, reviewed 12/16/24, which indicated "...14. Ensure the catheter remains secured. A leg strap may be used to reduce friction and movement at the insertion site...15. Be observant of skin irritation...20...k. Assess the urethral meatus... m. For the male: Use a wipe or washcloth with periwash to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward...Return foreskin to normal position. n. Use a clean wipe or washcloth with periwash to cleanse and rinse the catheter from insertion site to approximately four inches outward...Be sure the catheter tubing and drainage bag are kept off the floor ... wash and dry hands after performing catheter care " On 4/1/25 at 1:15 P.M., a current Suprapubic Catheter Care Policy, last reviewed 12/16/24, was provided by the Interim DON and indicated, " ... The urinary drainage bag should be held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder ... " On 4/1/25 at 1:44 P.M., a current Urinary Leg Bag Catheter Policy, last reviewed 12/16/24, was provided by the Interim DON and indicated, "To provide guidelines to decrease the likelihood of nosocomial urinary tract infections associated with the intermittent use of leg drainage bags ... Every attempt should be made to maintain a closed urinary drainage system ... Leg drainage bags should be used only after careful consideration and after a decision has been made that, the benefits of use of the bag outweigh the potential increased risk of urinary tract infection. The resident should be informed that there is			

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	increased risk of infection when the integrity of the closed urinary drainage system is compromised. The regular straight drainage bag should be reconnected only if it appears that the integrity of the system has been maintained. Aseptic technique should be used when handling urinary drainage systems ... Keep the drainage bag in a safe place where it will not be mishandled. Continue to keep drainage bag beneath the drainage tubing to prevent contamination ... cleaning and storage of urinary bags: rinse drainage bags with cold water. Cleanse with 1:7 vinegar and water or chlorine bleach solution of 1:33 [1 ounce of chlorine bleach to 1 liter of water]. May use a syringe to reach inlet and outlet adequately; open outlet valve and cleanse thoroughly. Completely immerse bag in cleaning solution for approximately 15-20 minutes. Dry and store in a designated manner where it will not be contaminated." This citation relates to Complaint IN00456575 and Complaint IN00456619. 3.1-41(a)(1) 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to provide care consistent with professional standards of practice for 1 of 2 residents reviewed for respiratory care. A resident's order for oxygen supplementation was not followed. (Resident 7) Finding includes: On 3/25/25 at 11:09 A.M., Resident 7 was laying	F 0695	1. Resident #7 suffered no ill effects from the alleged deficient practice. Resident was assessed with no concerns. Oxygen order was verified in the electronic medical record. The flow rate was verified to be set at 2L per physician order. Resident #7 oxygen tubing was immediately changed and stored appropriately.	05/01/2025

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	sideways in bed wearing oxygen per nasal cannula with the oxygen concentration machine indicator between 2.5-3 liters per minute (LPM). On 3/28/25 at 9:53 A.M., Resident 7 was sitting in her room in a Broda chair asleep wearing oxygen per nasal cannula. The oxygen concentrator on the portable tank was set on 3 LPM. On 4/2/25 at 10:35 A.M., Resident 7's Broda chair was in the resident's private bathroom and the nasal cannula tubing was hanging over the Broda chair, uncovered. On 3/31/25 at 11:51 A.M., Resident 7's clinical record was reviewed. Diagnoses included, congestive heart failure and chronic obstructive pulmonary disease (COPD). The most recent Discharge Minimum Data Set (MDS), dated 3/19/25 indicated Resident 7's cognition was moderately impaired and she wore oxygen. Physician's Orders included, but were not limited to, oxygen at 2 LPM per nasal cannula continuously, ordered 11/6/24 and discontinued 3/19/25 Oxygen at 2 LPM per nasal cannula continuously, ordered 3/26/25 A current Shortness of Breath related to COPD Care Plan, initiated 11/3/19 and last reviewed 1/28/25, included, but was not limited to, an intervention to administer oxygen per orders, initiated 11/3/19 Progress notes indicated the resident left the facility on 3/19/25 at 7:35 A.M. and returned to the facility on 3/20/25 at 2:48 P.M.		Nursing staff were immediately educated on verification of oxygen orders and appropriate storage of oxygen tubing. 2. All like residents have the potential to be affected. Licensed nursing staff to be educated on ensuring oxygen orders are implemented and followed. Licensed nursing staff to be educated on appropriate storage of oxygen tubing. 3. As a measure of ongoing compliance, the DHS or designee will audit 5 like residents to ensure oxygen flow rate set per MD order weekly x4 weeks, then every other week x2 months, then monthly x3 months. As measure of ongoing compliance, the DHS or designee will audit to ensure Oxygen order is placed in electronic health record per MD order. Audits to be completed on 5 like residents weekly x4 weeks, then every other week x2 months, then monthly x3 months The DHS or designee will audit 5 like residents for appropriate oxygen tubing storage 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	

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	During an interview on 4/1/25 at 2:23 P.M., Licensed Practical Nurse (LPN) 5 indicated the nurse's were allowed to initiate oxygen as a nursing measure, but they were supposed to get an order for it as soon as possible from the physician. She indicated Resident 7 should be on 2 LPM and had been for a long time. She was unsure why Resident 7's oxygen order was not restarted after she returned from the hospital until 3/26/25. During an interview on 4/2/25 at 11:18 A.M., Certified Nurse Aide (CNA) 23 indicated Resident 7 had been on oxygen as long as she had worked at the facility and she did not believe Resident 7 would be able to adjust the oxygen concentration indicator on the machine. On 4/2/25 at 10:57 A.M., a current Respiratory Equipment Policy, last reviewed 12/16/24, was provided by the Interim Director of Nursing (DON) and indicated, "To provide infection control guidelines to help prevent infections associated with respiratory therapy equipment and to prevent transmission of infections to residents ... Keep oxygen cannula and tubing used PRN [as needed] in a plastic bag when not in use ... " On 4/2/25 at 11:44 A.M., a current Oxygen Administration Policy, last reviewed 12/13/24, was provided by the Interim Director of Nursing (DON) and indicated, " ... verify physician's order for the procedure. In cases of emergency oxygen may be administered as a nursing intervention until a physician order may be obtained ... " 3.1-47(a)(6)		Improvement meetings. The plan will be reviewed and updated as warranted. ---	

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F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff was provided for 7 of 7 days reviewed and 1 of 1 Resident Council meeting. Oxygen orders were not in place, catheter care was not provided, antibiotics given were not indicated for uti, and showers were not given. (Resident 33, Resident E, Resident B, Resident D, Resident C) Finding includes: 1. During the survey dates of 3/25/25 through 4/2/25, the following interviews were completed. a. The confidential interview indicated it was dependent on the hall assigned and if everyone showed up whether there was enough help or not. She frequently stayed after her shift ended to chart. They indicated it would be better and they could get all tasks done if there were two aides on each hall (100/Locked Dementia Unit, 200/TCU, and 300) or at least a float Certified Nurse Aide (CNA) that would be available as needed. b. The confidential interview indicated they were not able to get a break or get a lunch. They indicated there were a lot of call in's. Staff would try to call others to replace them, but that didn't always happen. c. The confidential interview indicated the 200/TCU and 300 Halls need 2 CNAs. They indicated nurses help some but they need to get their work done too. So aides have to leave their hall and go find someone else. If there weren't enough aides, the residents didn't get what they need or they have to wait too long and that's when accidents happen. They indicated they	F 0725	1. Residents 33, E, B, D and C suffered no ill effects from the alleged deficient practice. All like residents were assessed with no concerns. 2. All like residents have the potential to be affected. The Director of Health Services (DHS) conducted an audit of all like residents, without any other deficiencies noted. Clinical scheduling reviewed and staffing patterns reviewed to ensure needs of residents are met for the following: oxygen orders are in place per MD order, catheter care provided per policy, showers are offered, given and documented in medical record and antibiotics are ordered for appropriate indication of use. IDT (interdisciplinary team) educated on staffing standards of practice 3. As a measure of ongoing compliance, ED or designee will audit clinical schedule to ensure adequate staffing patterns are adhered. Audits to be completed 3x/week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, and monthly x 3 months. As a measure of ongoing compliance, the DHS or designee will audit 5 like residents to ensure oxygen orders are set per MD order weekly x4 weeks, then every other week x2 months, then	05/01/2025

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	would come in early or stay late if needed to get tasks done. They felt like there are a couple people that call in during a week's time and sometimes they can get someone to cover and sometimes not. Managers help if they can, but they have their work to get done as well. d. During an interview on 4/2/25 at 10:14 A.M., the Scheduler indicated they have call in's a couple times per week. They try to call other staff and if they can't find someone, the manager on call will step in. Based on the current census, ideally they would have one nurse and one CNA on each hall for every shift. She indicated all their available CNA positions were filled except maybe one opening on night shift. 2. A review of the current Facility Assessment Tool, last updated 1/7/25, was provided by the Executive Director and indicated an average daily census (as of January 2024) was 35 residents with a total licensed skilled bed count of 58 residents available. Based on the resident population and their needs for care and support, six Licensed Practical Nurses (LPNs) and 13 Nurse Aides (CNAs), and two other nursing personnel with administrative duties were needed to ensure the facility had sufficient nursing staff per day. The general approach taken to assess staffing needs were to evaluate acuity, census, and staffing budget to ensure sufficient staff to meet the needs of the residents at any given time. Furthermore, campus leaders met regularly to discuss all clinical needs of each resident and then made staffing adjustments accordingly. 3. A review of the Dementia Disclosure, dated 12/31/24, was provided by the Executive Director and indicated the resident census number on the 100 Hall/Locked Dementia Unit was 14 at that time and required one LPN on day shift and evening		monthly x3 months. As a measure of ongoing compliance The DHS or designee will audit 5 like residents for appropriate catheter care weekly x4 weeks, then every other week x2 months, then monthly x3 months As a measure of ongoing compliance The DHS or designee will audit 5 residents for to ensure shower/bathing are provided and documented appropriately per preference, weekly x4 weeks, then every other week x2 months, then monthly x3 months The DHS or designee will audit 5 antibiotic orders, as warranted, to ensure appropriate treatment with appropriate diagnosis: weekly x2 months, then every other week x2 months, then monthly x2 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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	shift, one Qualified Medication Aide (QMA) on night shift, one CNA on day shift, evening shift, and night shift. 4. A current resident list of all skilled residents and a list of resident assistance levels needed, were provided by the Interim Director of Nursing (DON) and reviewed, along with confidential staff interviews, indicated the following: a. The 200 Hall had 16 residents. There were three residents totally dependent on staff and one resident was a two person assist of staff. b. The Transitional Care Unit (TCU) had 9 residents, one of them was a two person assist of staff. c. The 300 Hall had 13 residents. Two residents were two person assist of staff, three residents were totally dependent on staff, and one resident was totally dependent on staff to feed her. d. The Locked Dementia Unit had 12 residents. Two residents were two person assist of staff, one resident was totally dependent on staff, and 3 residents required assistance eating. e. Residents needed assistance for showers on the following days: Monday day shift-six, evening shift-four; Tuesday day shift-seven, evening shift-seven, Wednesday day shift-five, evening shift-five; Thursday day shift-five, evening shift-five; Friday day shift-eight, evening shift-six; Saturday day shift-five, evening shift-six; Sunday evening shift-one. 5. Daily Staffing Assignment Sheets "as worked" from Wednesday, March 19, 2025 to Tuesday, March 25, 2025, were provided by the Executive Director and indicated the following: a. 3/19/25 Resident Census-48 Day Shift (6:00 A.M.-2:00 P.M.): 200 Hall-one Registered Nurse (RN) and one CNA			

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	TCU-one LPN and one CNA 300 Hall-one LPN and one CNA Locked Dementia Unit-one LPN, no CNA from 6:00-10:00 A.M., and 1 CNA from 10:00 A.M.-2:00 P.M. Evening Shift (2:00-10:00 PM): 200 Hall-one RN and one CNA TCU-one LPN and one CNA 300 Hall-one LPN from 2:00-6:00 P.M. and one Qualified Medication Aide (QMA) from 6:00-10:00 P.M., one CNA Locked Dementia Unit-one LPN and one CNA Night Shift (10:00 P.M.-6:00 A.M.): 200 Hall-one RN and one CNA TCU-one CNA 300 Hall-one QMA and one CNA Locked Dementia Unit-one CNA b. 3/20/25 Resident Census-48 Day Shift: 200 Hall-one LPN and one CNA from 6:00-11:00 A.M. TCU-one LPN and one CNA 300 Hall-one RN and one CNA Locked Dementia Unit-One LPN and one CNA from 10:00 A.M.-2:00 P.M. Evening Shift: 200 Hall-one LPN from 2:00-6:00 P.M., one RN from 6:00-10:00 P.M., one CNA from 4:00-10:00 P.M. TCU-one CNA 300 Hall-one RN from 2:00-6:00 P.M., one QMA from 6:00-10:00 P.M., and one CNA Locked Dementia Unit-one LPN from 2:00-6:00 P.M. and one CNA Night Shift: 200 Hall-one RN and one CNA TCU-no staff listed 300 Hall-one QMA and one CNA Locked Dementia Unit-one CNA			

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	c. 3/21/25 Resident Census-48 Day Shift: 200 Hall-one RN and one CNA TCU-one CNA 300 Hall-one LPN and one CNA Locked Dementia Unit-one LPN and one CNA Evening Shift: 200 Hall-one RN from 2:00-6:00 P.M., one QMA from 6:00-10:00 P.M., and one CNA TCU-one LPN and one CNA from 2:00-6:00 P.M. 300 Hall-one QMA and one CNA Locked Dementia Unit-one QMA and one CNA Night Shift: 200 Hall-one QMA and one CNA TCU-one RN 300 Hall-one LPN and one CNA Locked Dementia Unit-one CNA d. 3/22/25 Resident Census-49 Day Shift: 200 Hall-one RN and one CNA from 6:00-10:00 A.M., one QMA from 10:00 A.M.-2:00 P.M. TCU-no nurse listed, one CNA 300 Hall-one RN and one CNA Locked Dementia Unit-one RN and one CNA Evening Shift: 200 Hall-one RN and one CNA TCU-one QMA and one CNA 300 Hall-one RN from 2:00-6:00 P.M., one QMA from 6:00-10:00 P.M., and one CNA Locked Dementia Unit-one RN from 2:00-6:00 P.M. and one CNA Night Shift: 200 Hall-one RN and one CNA TCU- one CNA 300 Hall-one "nurse" and one CNA Locked Dementia Unit-one CNA e. 3/23/25 Resident Census-49			

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	Day Shift: 200 Hall-one RN TCU-one CNA from 10:00 A.M.-2:00 P.M. 300 Hall-one RN and one CNA Locked Dementia Unit-one RN and one CNA Evening Shift: 200 Hall-one RN and one CNA TCU-one QMA and one CNA 300 Hall-one RN and one CNA Locked Dementia Unit-one RN from 2:00-6:00 P.M. and one CNA Night Shift: 200 Hall-one RN and one CNA TCU-one CNA 300 Hall-one RN and one CNA and one CNA to float Locked Dementia Unit-one CNA f. 3/24/25 Resident Census-50 Day Shift: 200 Hall-one LPN and one CNA TCU-no staff listed 300 Hall-one LPN and one CNA Locked Dementia Unit-one RN and one CNA Evening Shift: 200 Hall-one RN and one CNA TCU-one CNA 300 Hall-one RN and one CNA Locked Dementia Unit-one QMA Night Shift: 200 Hall-one RN and one CNA TCU-no staff listed 300 Hall-one RN and one CNA Locked Dementia Unit-One CNA g. 3/25/25 Resident Census-50 Day Shift: 200 Hall-1 RN and one CNA from 6:00-11:00 A.M. TCU-one CNA from 10:00 A.M.-2:00 P.M. 300 Hall-one LPN from 2:00-6:00 P.M., one QMA			

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	from 6:00-10:00 P.M., and one CNA Locked Dementia Unit-one LPN from 2:00-6:00 P.M. and one CNA Evening Shift: 200 Hall-one RN and one CNA TCU-no staff listed 300 Hall-one QMA and one CNA Locked Dementia Unit-one CNA Night Shift: 200 Hall-one RN and one CNA TCU-no staff listed 300 Hall-one QMA and one CNA Locked Dementia Unit-one CNA 6. Resident Concern Forms (grievances) for the last 3 months were provided by the Executive Director and included the following dates they were submitted: a. 1/2/25, from resident council: "Ice water is not getting done on third shift and day shift the past two days. Ice water was not getting passed a lot last week and problem a lot of times on third shift. They leave water outside our rooms and we can't get to it. By the time day shift gets here, it's hot." b. 1/27/25 from a family member: "Grooming - not being done on resident and he is staying in bed over the weekends." c. 1/28/25 from resident council: "Grooming - showers on second shift ... residents do not want at 9-9:30 P.M. TOO LATE." d. 1/28/25 from resident council: "Call light/waiting- call lights too long of wait. Aide comes in, turns off light, and never returns." e. 2/12/25 from a resident: "Grooming - resident had not received a shower since admission." f. 2/14/25 from a resident: "Positioning and safety - resident is supposed to have his leg iced and has not had it done all day. Wife stated she had to do it yesterday because nobody else would." g. 2/14/25 from a resident: "Grooming - resident			

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	states he has not had a shower since he has been here. Wife is upset as well." h. 2/18/25 from a resident: "Call light/waiting - resident very upset, states he asked for his ice bottles for his knee 4 different times to 4 different people." i. 2/25/25 from a family member: "Clinical - Feeding tube - wife called this morning very angry due to the fact that she had picked him up this morning and his feeding tube had not been flushed so when she finally looked at his tube at dialysis, there was build up in her words 'concrete was stuck there'." j. 2/26/25 from a family member: "Grooming - Can we try to brush her teeth. I know she refuses sometimes but can you still try?" k. 3/4/25 from a resident: "Grooming - resident stated that she has not had a shower in one week. She did state that she had wanted times changed but that she is very upset that no on has offered to give her one." l. 3/4/25 from a resident: "Grooming - resident was suppose to get a shower on Monday night but did not get one." 7. A Resident Council meeting was held on 3/27/25 at 10:00 A.M., and residents voiced the following concerns about staffing: a. Resident only got one shower a week. They would like at least two showers a week. They indicated they told staff, but they told her there was not enough to do that. b. Resident indicated staff was short handed and call lights take awhile to answer, sometimes waits 20 minutes or more. c. Resident indicated they took water pill and waited for staff to put her on the bed pan. She finally had to roll her self off the bed pan because staff did not answer the call light. "One aide on the hall is not enough. One of the aides just quit			

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	because there was not enough help." 8. The lack of sufficient nursing staff resulted in showers not being completed. Cross Reference F677. 9. The lack of sufficient nursing staff resulted in a resident receiving an antibiotic that was not indicated for treatment of a urinary tract infection. Cross Reference F690. 10. The lack of sufficient nursing staff resulted in residents not receiving proper catheter care. Cross Reference F690. 11. The lack of sufficient nursing staff resulted in oxygen orders not being put in and not being followed. Cross Reference F695. This citation relates to Complaint IN00456575. 3.1-17(a)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control practices were implemented for a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for 2 of 2 random observations. (100 Hall, 300 Hall) Findings include:	F 0880	1. No residents were affected by the alleged deficient practice. Laundry #3 and #7 were immediately educated on proper infection control procedures during transport and handling of clean linen. 2. All residents have the potential to be affected. Facility staff to be	05/01/2025

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	1. On 4/1/25 at 10:14 A.M., a laundry cart was observed against a wall on the 100 Hall. Clothes were observed on hangers hanging from the top of the cart and folded items observed in the bottom basket. The cart was not covered. Laundry 3 and Laundry 7 were observed wheeling the cart down the hall while the clothes on the hangers were rubbing against the wall, resident doors, and hand sanitizer dispensers. Laundry 3 and Laundry 7 were observed taking the folded items from the basket and hugging them against their uniform tops taking them into the resident rooms. 2. On 4/1/25 at 2:14 P.M., Laundry 7 was observed on the 300 Hall holding resident clothing against her uniform top and entering room 304. Laundry 7 was then observed holding resident clothing in her left arm against her uniform top, obtained clothing that was on hangers from the laundry cart, and bent down, dragging the clothes on the hangers along the floor. She then took the items to room 307. On 4/2/25 at 11:06 A.M., the Infection Preventionist indicated clean clothing should not be against staff uniform shirts, and should be kept away from the body. He further indicated clean clothing should never drag along the floor before taken to a resident's room. On 4/2/25 at 10:57 A.M., the Interim Director of Nursing provided a current Handling Linen policy, dated 12/17/24, that indicated "Linens should be carried away from the body to prevent contamination from clothing" 3.1-18(b) 3.1-19(g)		educated on proper infection control procedures during transport and handling of clean linen. 3. As a measure of ongoing compliance, the DHS or designee will audit for proper infection control procedures during transport and handling of clean linen 3 times weekly x1 month, then weekly 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. ---	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Nursing Home Complaints IN00456575 and IN00456619. Complaint IN00456575 - Federal/State deficiencies related to the allegations are cited at F725 and F690. Complaint IN00446619 - Federal/State deficiencies related to the allegations are cited at F 677 and F690. Survey dates: March 25, 26, 27, 28, 31, April 1, 2, 2025 Facility number: 013332 Residential Census: 30 The Villages of Oak Ridge was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	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 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.	