STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Village	200 W Fourth St Oaktown, IN 47561

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39130 Based on interview and record review, the facility failed to ensure accurate and appropriate medication administration practices were in place for 1 of 3 residents reviewed for pharmaceutical services. A resident received another resident's medications after the administering nurse preset residents' medications prior to the medication pass. (Resident C) Finding includes: On 4/1/25 at 10:45 A.M., an Indiana Department of Health (IDOH) Facility Reportable Incident (FRI) form, dated 3/23/25 at 1:01 P.M., indicated Resident C was given incorrect medications in error. The follow-up FRI, dated 3/28/25, indicated a RN 4 had set up medications prior to administering them and Resident C received the wrong medications. During record review on 4/1/25 at 11:00 A.M., Resident C's diagnoses included but was not limited to, paraplegia, anemia, depression, and seizures. Resident C's care plan included, but was not limited to, resident had an alteration in gastro-intestinal status (initiated 3/19/25) with an intervention that included, administer medications as ordered. Resident had an alteration in neurological status (initiated 3/19/25) with an intervention that included, administer medications as ordered. Resident C's nurse's progress notes included, but were not limited to: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/23/25 at 8:00 A.M. - Incident Note - RN 4 accidentally gave resident the incorrect medication. Resident received the following medications: amiodarone 200 (milligrams) mg (antiarrhythmic), amlodipine 5 mg (can treat high blood pressure), aspirin 81 mg, clonidine 0.3 mg (can treat high blood pressure), docusate sodium 100 mg (stool softener), Eliquis 5 mg (anticoagulant), ferrous sulfate 324 mg (iron supplement), furosemide 40 mg (diuretic), isosorbide 30 mg (nitrate, can treat chest pain related to heart disease), metoprolol 25 mg (can treat high blood pressure), potassium 20 milliequivalent (mEq) (supplement), topiramate 25 mg (anticonvulsant), vitamin B 12 50 micrograms (Mcg) (supplement), vitamin C 250 mg (supplement), vitamin D 3 25 Mcg (supplement). Orders were obtained to start fluids and two attempts were made to start intravenous (IV) access without success. Resident was sent to hospital to start IV access site to receive fluids and for further observation. During an interview on 4/1/25 at 11:35 A.M., the Director of Nursing (DON) indicated Resident C had received another resident's medications the morning of 3/23/25 after RN 4 had preset medications prior to the medication pass. After administering medications to Resident C, RN 4 returned to the medication cart and realized that another resident's medications had just been given to Resident C and Resident C's medications were still in the medication cart. The DON indicated nursing staff should not preset medications and should always ensure the correct medications are administered to the correct resident. Resident C's hospital ED (Emergency Department) physician notes, dated 3/23/25 at 9:23 A.M., indicated the resident presented to the ED after she had received incorrect medications. The resident stated that she felt weird and she was hypotensive with a blood pressure of 93/52. Resident received IV fluids and her blood pressure improved. All other labs were within normal limits (WNL). On 4/1/25 at 11:45 A.M., the DON supplied a facility policy titled, Administering Medications, dated 12/2012. The policy included, Medications shall be administered in a safe and timely manner, and as prescribed . 6. The individual administering the medication must verify the right resident, right medications, right dosage, right time, and right method (route) of administration before giving the medication . The deficient practice was corrected on 3/27/2025 after the facility implemented a systemic plan that included the following actions: Ad HOC QAPI meeting was held on 3/24/25, an action plan included inservice review of policy for medication administration with staff, observations of medication pass, assessment of all residents and the on going monitoring of the medication passes. This citation relates to complaint IN00456371. 3.1-25(b)(5) 3.1-25(b)(7)