

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/20/2024
NAME OF PROVIDER OR SUPPLIER  Oak Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>49068</p> <p>Based on record review and interview, the facility failed to ensure a care plan was created for dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with daily life and activities) for 1 of 1 residents reviewed for Preadmission Screening and Resident Review (PASRR) (Resident 2), and failed to ensure a person-center dementia care plan interventions were in place for 1 of 1 resident reviewed for dementia care (Resident 21).</p> <p>Findings include:</p> <p>1. During an initial pool record review, on 9/17/24 at 9:41 a.m., a Level I PASRR was observed and indicated that Resident 2 required a Level II evaluation. Further review was required to locate the Level II evaluation information.</p> <p>A record review for Resident 2 was conducted on 9/18/24 at 11:16 a.m. The profile indicated the resident diagnoses included, but were not limited to, dementia with unspecified severity, without behavioral disturbance, psychotic (when you perceive or interpret reality in a very different way from people around you) disturbance, mood disturbance (a category of mental illnesses that affect a person's mood, or emotional state), and anxiety (a feeling of fear, dread, and uneasiness that can be a normal reaction to stress); and mild intellectual disabilities (a condition that affects a person's ability to learn, think, and adapt to their environment).</p> <p>A scanned document, dated 8/11/17, titled, Notice of PASRR Level I Screen Outcome, PASRR Level II Onsite Evaluation Required, indicated the PASRR Level I outcome required a Level II evaluation. The diagnoses evaluation indicated the resident had dementia/neurocognitive (a decrease in mental function caused by a medical disease, rather than a psychiatric illness) disorder, with significant short-term and long-term memory impairment.</p> <p>A scanned document, titled, Inappropriate Referral for PASRR/MI (mental illness) level II, dated 8/16/17, had #2 marked and indicated, Questions #2-5 would trigger a Level II assessment, but the person is excluded from the Level II because there is a diagnosis of dementia .without a primary diagnosis of major mental illness (MI) or any diagnosis of mental retardation/developmental disability A handwritten note below it indicated, dementia is primary impairment in executive functioning, memory impairment, and cognitive impairment</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A quarterly Minimum Data Set (MDS) Assessment, dated 7/2/24, indicated Resident 2 had a diagnosis of non-Alzheimer's dementia (a group of diseases characterized by progressive deficits in behavior, executive function, or language).</p> <p>During an interview on 9/19/24 at 2:17 p.m., the Regional Director of Clinical Services (RDCS) indicated she was unable to find information related to dementia or cognition in Resident 2's current or resolved/historical care plans. The resident had a diagnosis of dementia and should have had a related care plan.</p> <p>On 9/19/24 at 2:22 p.m., the RDCS provided a policy with a revised date of 7/23/09, titled, Care Planning and Interventions, and indicated it was the policy currently being used by the facility. The policy indicated, . Standard, the interdisciplinary team meets on a scheduled basis and develops an individualized care plan. Interdisciplinary means that professional disciplines, as appropriate, work together to provide the greatest benefit to the resident .Practice Guidelines .interventions for preventing avoidable declines in functioning or functional levels</p> <p>34525</p> <p>2. Resident 21's record was reviewed on 9/17/24 at 1:34 p.m. The profile indicated the resident's diagnoses included, but were not limited to, dementia with agitation (a condition where a person with dementia experiences restlessness and worry, and is unable to settle down), dementia with psychotic disturbance (occurs when a person with dementia experiences hallucinations and/or delusions), and anxiety disorder (a mental health condition that involves excessive and persistent feelings of fear, worry, dread, and uneasiness).</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/10/24, indicated the resident had moderate cognitive deficit and experienced behaviors of rejection of care and wandering.</p> <p>A care plan, dated 12/15/23 indicated the resident was at risk for exhibiting behaviors related to dementia diagnosis and had a history of behaviors. Interventions included, but were not limited to, code alert to right wrist and encourage resident to attend activities. The care plan lacked documentation of specific person-centered interventions.</p> <p>A care plan, dated 1/29/24, indicated the resident had behavior monitoring in place due to resident being resistive to care due to</p> <p>dementia. Interventions included, but were not limited to, allow the resident time to verbalize feelings and approach resident in non-threatening manner. The care plan lacked documentation of specific person-centered interventions.</p> <p>A review of the resident's Kardex (a system for organizing and referencing patient information, typically used by nurses), indicated the form lacked documentation of any person-centered information or interventions for the resident.</p> <p>A review of the staff assignment sheets indicated the sheets lacked documentation of any person-centered information or interventions for the resident.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 9/17/24 at 3:08 p.m., the interim Director of Nursing (DON) indicated she had reviewed the resident's care plan, and she was unable to find any information that was specific to the resident. The care plan interventions were generic in nature.</p> <p>On 9/17/24 at 3:17 p.m., the interim DON provided a document, with a revised date of 9/2022, titled, Care Plans, Comprehensive Person-Centered, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Interpretation and Implementation .7. The care planning process will: .c. Incorporate the resident's personal and cultural preferences. 8 .Incorporate interventions to address cultural needs, psychosocial needs, mitigate/reduce risk for trauma related triggers .10. Identifying .and developing interventions that are targeted and meaningful to the resident</p> <p>3.1-35(b)(1)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>35317</p> <p>Based on interview and record review, the facility failed to ensure care plan meetings were conducted quarterly for 3 of 16 residents reviewed for care plan meetings (Residents 3, 6, and 12).</p> <p>Findings include:</p> <p>1. During an interview, on 9/17/24 at 9:58 a.m., Resident 3 indicated she could not remember being invited to or attending a care plan meeting recently. She could not recall when the last one was.</p> <p>Resident 3's record was reviewed on 9/17/24 at 1:28 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/29/24, indicated the resident had no cognitive impairment.</p> <p>A care plan note, dated 3/26/24 at 10:30 a.m., indicated a care plan meeting was conducted on this day for Resident 3.</p> <p>Resident 3's record lacked documentation of quarterly care plan meetings being conducted in the last 12 months. The resident only had one care plan meeting in the last year.</p> <p>During an interview, on 9/17/24 at 2:27 p.m., the Social Service Director (SSD) indicated she unable to find any additional documentation of quarterly care plan meetings being conducted for Resident 3. She indicated she had not been in this position long at this facility and she was aware they were behind on the meetings. The SSD indicated the care plan meetings should be conducted quarterly on each resident.</p> <p>2. During an interview, on 9/16/24 at 10:59 a.m., Resident 6 indicated she was not aware if the facility had care plan meetings because she does not remember being invited to or attending one.</p> <p>Resident 6's record was reviewed on 9/17/24 at 2:52 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/31/24, indicated the resident had no cognitive impairment.</p> <p>A care plan note, dated 2/19/24 at 2:23 p.m., indicated a care plan meeting was conducted on this day for Resident 6.</p> <p>A care plan note, dated 11/28/23 at 10:22 a.m., indicated a care plan meeting was conducted on this day for Resident 6.</p> <p>Resident 6's record lacked documentation of quarterly care plan meetings being conducted since 2/19/24. The resident only had two care plan meetings in the last year.</p> <p>During an interview, on 9/17/24 at 2:50 p.m., the Social Service Director (SSD) indicated she was unable to provide documentation of any care plan meetings being conducted since 2/19/24.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. During an interview, on 9/16/24 at 2:01 p.m., Resident 12 indicated she did not remember being invited to or attend a care plan meeting recently. She indicated she had only remembered being to one the whole time she had been at the facility.</p> <p>Resident 12's record was reviewed on 9/17/24 at 3:04 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/3/24, indicated the resident had no cognitive impairment.</p> <p>A care plan noted, dated 12/26/23 at 11:12 a.m., indicated a care plan meeting was conducted on this day for Resident 12.</p> <p>Resident 12's record lacked documentation of quarterly care plan meetings being conducted in the last 12 months. The resident only had one care plan meeting in the last year.</p> <p>During an interview, on 9/17/24 at 3:18 p.m., the Social Service Director (SSD) indicated she was unable to provide documentation of any care plan meetings being conducted since 12/26/23.</p> <p>On 9/17/24 at 3:09 p.m., the Director of Nursing (DON) provided a document, with a revised date of December 2016, titled, Resident Participation- Assessment/Care Plans, and indicated it was the policy currently being used by the facility. The policy indicated, .1. The resident and his or her legal representative are encouraged to attend and participate in the resident's assessment and in the development of the resident's person-centered care plan .7. A seven (7) day advance notice of the care plan conference is provided to the resident and his or her representative. Such notice is made by mail and/or telephone</p> <p>3.1-35(e)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>49068</p> <p>Based on interview, observation, and record review, the facility failed to provide activities when the Activity Director was out of the building for 6 of 7 residents reviewed for activities (Residents 2, 10, 25, 13, 3, and 12).</p> <p>Findings include:</p> <p>1. During an interview on 9/16/26 at 11:22 a.m., Resident 2 indicated she liked to play bingo, but nobody was there to do activities and the staff do not work.</p> <p>On 9/17/24 at 1:36 p.m., observed a posted activities calendar in the hallway for the month of September 2024. The posted activities calendar indicated the facility would have the following activities for 9/16/24 at 9:00 a.m. Manic Monday, 10:00 a.m. EZ does it, 11:00 a.m. Devotion, and 2:00 p.m. Fancy Nails. None of the activities were observed to have taken place for 9/16/24.</p> <p>A record review was conducted for Resident 2's on 9/18/24 at 11:16 a.m. The profile indicated the resident diagnoses included, but were not limited to, dementia with unspecified severity, without behavioral disturbance, psychotic (when you perceive or interpret reality in a very different way from people around you) disturbance, mood disturbance (a category of mental illnesses that affect a person's mood, or emotional state), and anxiety (a feeling of fear, dread, and uneasiness that can be a normal reaction to stress); and mild intellectual disabilities (a condition that affects a person's ability to learn, think, and adapt to their environment).</p> <p>A quarterly Minimum Data Set (MDS) Assessment, dated 7/2/24, indicated Resident 2 was cognitively intact.</p> <p>An activities assessment, dated 6/19/24, indicated that it was very important to Resident 2 to do things with groups of people.</p> <p>2. During an interview on 9/16/24 at 2:25 p.m., Resident 10 indicated that she missed the old staff because they had a new Activity Director now and no longer had activities like they used to. Now, she was bored all the time.</p> <p>On 9/17/24 at 1:36 p.m., observed a board with a posted activities calendar for the month of September 2024. The posted activities calendar indicated the facility would have the following activities for 9/16/24: 9:00 a.m. Manic Monday, 10:00 a.m. EZ does it, 11:00 a.m. Devotion, and 2:00 p.m. Fancy Nails. None of the activities were observed to have taken place for 9/16/24.</p> <p>During an interview on 9/18/24 at 1:24 p.m., Resident 10 indicated that she was interested in participating in the scheduled activities today because they were not what they used to be, and they were no longer fun.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review was conducted for Resident 10 on 9/20/24 at 11:21 a.m. The profile indicated the resident diagnoses included, but were not limited to, multiple sclerosis (a chronic disease that affects the central nervous system, including the brain and spinal cord), major depressive disorder (a serious mood disorder that can impact a person's daily life), and dependence on wheelchair.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/26/24, indicated that the resident was cognitively intact.</p> <p>During an interview on 9/20/24 at 12:00 p.m., Resident 10 indicated they did not have activities on the weekends at all. If they did, they would not be worth her time to attend anymore.</p> <p>During an interview on 9/20/24 at 11:38 a.m., Registered Nurse (RN) 13 indicated that when the Activity Director was not there, the facility designated Certified Nursing Assistant (CNA) 11, or someone else, for activities.</p> <p>During an interview on 9/20/24 at 2:22 p.m., CNA 11 indicated she was often assigned to fill in and conduct activities. There had been many times that she was not able to fulfill the activities schedule because she was pulled to the floor to work as a CNA approximately 30% of the time. It was impossible to do both. The facility cut the activity budget and decreased how much staff were compensated for it, now nobody wanted to work doing activities for that kind of money. Due to census, they also cut back how many CNAs they scheduled from 3 per shift down to 2. This morning, she was supposed to fill in for activities, but she was again pulled to the floor instead. The Activity Director was gone twice per week for her schooling, she was going to school to be a Nurse and working on her Administrator's license. A lot of the residents complained about not having activities, it was a big concern for them. Nothing was left out for them to do or have access to on the weekends. The door was always open, and the light would be on, but nobody initiated the activities for them. Unless someone brought the residents to the activities room, they would not do it on their own.</p> <p>35317</p> <p>3. During an interview, on 9/17/24 at 9:56 a.m., Resident 3 indicated the facility can get boring on the weekends because they do not have activities. She also indicated the Activity Director did not work every day and if she was not here, they did not have activities.</p> <p>No facility activities were observed being conducted during the hours of 9:45 a.m. to 3:15 p.m. on 9/16/24.</p> <p>Resident 3's record was reviewed on 9/17/24 at 1:28 p.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia (high blood glucose levels), paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and diverticulosis (a condition in which small, bulging pouches develop in the digestive tract).</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/29/24, indicated Resident 3 had no cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A care plan, dated 4/11/23, indicated the resident wished to participate in group activities of her choosing. Interventions included, but were not limited to, the resident would receive an activity calendar monthly that would allow the resident to choose activities that interest her.</p> <p>A care plan, dated 11/8/23, indicated the resident had personal preferences for activities. Interventions included, but were not limited to, she likes manicures, coffee socials, small, and large group activities.</p> <p>An activity evaluation, dated 6/19/24, the evaluation indicated it was very important to Resident 3 to do things with groups of people. It was also very important to Resident 3 to be involved in her favorite activities.</p> <p>During an interview, on 9/19/24 at 9:38 a.m., Licensed Practical Nurse (LPN) 14 indicated there were days where there were no activities being conducted for the residents. She indicated there was only 1 activity personnel that worked at the facility, and she wasn't there every day.</p> <p>4. During an interview, on 9/16/24 at 1:58 p.m., Resident 12 indicated the facility didn't have a lot of activities and there were a lot of weekends when they didn't have anything.</p> <p>No facility activities were observed being conducted during the hours of 9:45 a.m. to 3:15 p.m. on 9/16/24.</p> <p>Resident 12's record was reviewed on 9/17/24 at 3:04 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), pneumonia (infection that inflames air sacs in one or both lungs which may fill with fluid), hypertension (high blood pressure), and complete traumatic amputation at knee level, left lower leg (severe injury that results in the complete loss of the lower leg below the knee).</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/3/24, indicated Resident 12 had no cognitive impairment.</p> <p>A care plan, dated 12/23/20, indicated the resident would make her own decisions as to what activities she would like to participate in. Interventions included, but were not limited to, parties/social events, bible/church study, outdoor time, and provide me the opportunity to do things with groups of people.</p> <p>A point of care (poc) response history for the last 30 days indicated Resident 12 had only participated in one social/event party on the weekends. The record lacked any other activity involvement on the weekends for the last 30 days.</p> <p>During an interview, on 9/19/24 at 9:38 a.m., Licensed Practical Nurse (LPN) 14 indicated there were days where there were no activities being conducted for the residents. She indicated there was only 1 activity personnel that worked at the facility, and she wasn't there every day.</p> <p>34525</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. During an interview, on 9/16/24 at 1:48 p.m., Resident 25 indicated the residents were not getting any activities on weekends unless they were self-initiated. They also usually only had one activity 1 per day during the week.</p> <p>No facility activities were observed being conducted during the hours of 9:45 a.m. to 3:15 p.m. on 9/16/24.</p> <p>Resident 25's record was reviewed on 9/18/24 at 8:50 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with neuropathy (high blood sugar levels in the blood which cause nerve damage, also known as neuropathy, over time), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out simple tasks), and stage 3 chronic kidney disease (a middle stage of kidney disease where the kidneys are mildly to moderately damaged and are less able to filter waste and fluid from the blood).</p> <p>An admission Minimum Data Set (MDS) assessment, dated 7/11/24, indicated the resident had moderate cognitive deficit.</p> <p>Review of the resident's care plans lacked documentation of an activity related care plan.</p> <p>An activity evaluation, dated 7/9/24, indicated it was somewhat important for the resident to do things with groups of people and to do her favorite activities.</p> <p>Review of the resident's individual activity tasks form, dated 8/20/24 through 9/15/24, indicated the resident had only participated in family visits on the weekends. The form lacked documentation that the resident had participated in any of the activities listed on the September 2024 Activity Calendar.</p> <p>During an interview, on 9/19/24 at 9:22 a.m., the Activity Director indicated the scheduler/Certified Nursing Assistant (CNA) 7 was scheduled to run the activities, during her absence on 9/16/24, but got pulled to work on the floor. CNAs 11 and 12 had been scheduled to run the activities on the weekends, but they also had been pulled to work the floor and have not been able to conduct the weekend activities as scheduled. Shortly after she began her position as Activity Director, the long-time Activity Assistant quit abruptly. She had not had an assistant since that time.</p> <p>6. During an interview, on 9/17/24 at 9:11 a.m., Resident 13 indicated there were very little activities on the weekends. Anything that was done had to be a self-directed type of activity. They also had not had any activity staff during the evenings. On 9/16/24, the Activity Director was out of the building taking some tests and there was no one available to run the activities. She also had classes every Wednesday, and was not in the building, so the activities on those days were hit-and-miss.</p> <p>No facility activities were observed being conducted during the hours of 9:45 a.m. to 3:15 p.m. on 9/16/24.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 13's record was reviewed on 9/19/24 at 9:14 a.m. The profile indicated the resident's diagnoses included, but were not limited to, stage 4 chronic kidney disease (a severe stage of kidney disease that occurs when the kidneys are damaged and can't filter waste from the blood as well as they should) and type 2 diabetes mellitus with neuropathy (high blood sugar levels in the blood which cause nerve damage, also known as neuropathy, over time).</p> <p>An annual Minimum Data Set (MDS) assessment, dated 7/10/24, indicated the resident had no cognitive deficit.</p> <p>A care plan, dated 4/19/21 and revised on 2/7/24, indicated the resident had personal preferences and preferred leisure activities over group activities, but would occasionally participate. Interventions included, but were not limited to, offer the resident the opportunity to participate in her favorite activities, offer her the opportunity to participate in new activities, and provide an activity calendar monthly to allow her to choose activities that interest her.</p> <p>An activity evaluation, dated 9/7/24, indicated it was very important for the resident to keep up with the news, and somewhat important for her to do things with groups of people and participate in her favorite activities.</p> <p>Review of the resident's individual activity tasks form, dated 8/20/24 through 9/15/24, indicated the resident had only participated in listening to her radio. The form lacked documentation that the resident had participated in any of the activities listed on the September 2024 Activity Calendar.</p> <p>During an interview, on 9/19/24 at 9:22 a.m., the Activity Director indicated the scheduler/Certified Nursing Assistant (CNA) 7 was scheduled to run the activities, during her absence on 9/16/24, but got pulled to work on the floor. CNA's 11 and 12 had been scheduled to run the activities on the weekends, but they also had been pulled to work the floor and have not been able to conduct the weekend activities as scheduled. Shortly after she began her position as Activity Director, the long-time Activity Assistant quit abruptly. She had not had an assistant since that time.</p> <p>On 9/19/24 at 10:21 a.m., the Activity Director provided a copy of the September 2024 Activity Calendar and indicated it was the plan of the scheduled activities for the month. The calendar indicated activities had been scheduled for all days during the month, running at 9:00 a.m., 10:00 a.m., 11:00 a.m., 2:00 p.m., and 3:00 p.m., on most days.</p> <p>On 9/19/24 at 10:21 a.m., the Activity Director provided a copy of a document which she indicated was the proposed schedule for activity staff for September 2024. The schedule indicated a staff had been assigned to conduct the events on the activity calendar from 8:00 a.m., to 4:00 p.m., on Mondays and Wednesdays, from 7:00 a.m., to 4:30 p.m., on Tuesdays, Thursdays, and Fridays, and times ranging from as early as 6:00 a.m., and as late as 6:00 p.m., on Saturdays and Sundays.</p> <p>On 9/19/24 at 10:36 a.m., the Regional Director of Clinical Services (RDCS) provided a document, dated 3/2015, titled, Activities/Recreation Administration, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Interpretation: .11. Perform all recreational activities on the calendar</p> <p>3.1-33(a)</p> <p>(continued on next page)</p>		

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F 0679  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	3.1-33(c)		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>35317</p> <p>Based on record review and interview, the facility failed to ensure there was not a delay in treatment for a resident who had a fall with complaints of pain and discomfort for 1 of 1 resident reviewed for delay in treatment (Resident 18).</p> <p>Finding includes:</p> <p>Review of matrix form (a form with pertinent information regarding residents' condition provided by the facility) on 9/17/24 at 9:09 a.m., indicated Resident 18 had a fall with injury on 7/4/24.</p> <p>Resident 18's record was reviewed on 9/18/24 at 2:19 p.m. The profile indicated the resident's diagnoses included, but were not limited to, fracture of unspecified a part of neck of left femur (a serious injury that occurs when the top of the leg bone breaks below the hip joint), pressure ulcer of unspecified heel (injury to skin and underlying tissue resulting from prolonged pressure on the skin), and unspecified dementia (mild cognitive impairment as yet to be diagnosed as a specific type of dementia).</p> <p>A significant change in status Minimum Data Set (MDS) assessment, dated 7/16/24, indicated the resident had severe cognitive deficit and had a pain assessment completed with a score of 8 out of 10. The resident was marked yes as having a fall while in the facility.</p> <p>A care plan, dated 2/2/24, indicated the resident had acute/chronic pain. Interventions included, but were not limited to, anticipate the resident's need for pain relief and respond immediately to any complaint of pain and evaluate the effectiveness of pain interventions per policy.</p> <p>A care plan, dated 2/2/24, indicated the resident was a high risk for falls. Interventions included, but were not limited to, 2 staff assist with all transfers, follow facility fall protocol, and anticipate and meet the resident's needs.</p> <p>A nursing note, dated 7/4/24 at 5:22 p.m., indicated Resident 18 was yelling for help and was found to be laying on her left side on the floor. Resident attempted to transfer herself out of her recliner and fell . Resident was assessed for injury, and none noted. The resident was able to move all extremities normally. The resident did complain of left leg pain. The resident was assisted to the bathroom and then to dining room for dinner. A message was left on the on-call phone for MD (Medical Doctor) notification and left a message for Director of Nursing (DON) per note.</p> <p>A nursing note, dated 7/4/24 at 6:24 p.m., indicated Resident 18 was complaining of increased pain to left leg, and were awaiting the physician's response. The record lacked documentation of any new orders.</p> <p>A nursing note, dated 7/5/24 at 3:45 a.m., indicated the resident had denied pain but was favoring her left side while ambulating. The record lacked documentation of the physician being notified.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note, dated 7/5/24 at 12:09 p.m., indicated the resident was resting in bed and had showed signs of pain while assessing her range of motion after recent fall. The resident groaned and stated she was in pain. The resident's pain appeared to be in the left hip. Physician was notified and an order for an x ray obtained. The record lacked documentation of an x-ray being completed on this day.</p> <p>A hospital triage notes, dated 7/6/24 at 12:41 a.m., indicated the resident had arrived to the emergency room from a fall 2 days ago at a facility with complaints of pain to buttocks and had tenderness to palpation to the left hip.</p> <p>An x-ray report, dated 7/6/24 at 2:10 a.m., indicated the resident had a left femoral neck fracture.</p> <p>A nursing note, dated 7/6/24 at 2:26 a.m., indicated the resident was sent to the hospital for a decline in her condition. The physician was notified and gave verbal orders to transfer her out to the hospital.</p> <p>During an interview, on 9/19/24 at 1:32 p.m., Licensed Practical Nurse (LPN) 14 indicated the nursing staff had several different ways they could contact the on-call physician. They had a secure messaging system they could use, and the physician can respond back on the system, there was an on-call cell phone number you could call, and during office hours they can call the physician's office.</p> <p>During an interview on 9/19/24 at 1:49 p.m., the Regional Director of Clinical Services (RDCS) indicated the facility had recently had a mock survey and they had identified a delay in treatment for Resident 18's fall on 7/4/24. They had already started an action plan during their QAPI (Quality Assurance and Performance Improvement) meeting. The licensed and certified nursing staff would be provided with education on fall prevention, post fall assessments, post fall pain management, delay in treatment, and send to emergency room if significant injury was suspected unless declined by physician.</p> <p>During an interview, on 9/19/24 at 3:15 p.m., the RDCS indicated the nursing staff may send out a resident without a physician order in the case of an emergency.</p> <p>On 9/19/24 at 2:02 p.m., the RDCS provided a document, with a revised date of March 2018, titled, Acute Condition Changes-Clinical Protocol, and indicated it was the policy currently being used by the facility. The policy indicated, .8. Nursing staff will contact the physician based on the urgency of the situation. For emergencies they will call or page the physician and request a prompt response (within approximately one-half hour or less). 9. The attending physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status. a. The nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response</p> <p>3.1-37</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>35317</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident had adequate pain control during a pressure ulcer dressing change for 1 of 1 reviewed for pain management (Resident 18).</p> <p>Finding includes:</p> <p>On 9/20/24 at 9:55 a.m., Resident 18 was observed sitting in her wheelchair in her room. Registered Nurse (RN) 13 and RN 24 were preparing supplies to complete a dressing change to the resident's wounds on her left heel.</p> <p>RN 13 and RN 24 completed a pressure ulcer dressing change to Resident 18's left heel and surrounding areas on 9/20/24 at 9:55 a.m. to 10:20 a.m. RN 24 removed an old dressing from Resident 18's left heel. After she removed the ace wrap and kerlix (gauze) wrap, she went to the bathroom to wash her hands. RN 13 then sat down and began to cleanse the wounds on the resident's left heel. When the nurse began to clean the wound the resident winced in pain, clenched her jaw and began to move her foot back away from the nurse. The resident indicated it was painful by verbalizing to the nurse that it hurt. The nurse continued with the dressing change. RN 13 indicated the resident had prn (as needed) pain medication and was pre-medicated prior to the dressing change with Norco (pain medication). At 10:13 a.m. RN 13 applied a lotion skin prep to the resident's top of her foot. The nurse was massaging her foot with the lotion and the resident winced again in pain, clenched her jaw, and jerked her foot away from the nurse. The resident again verbalized to the nurse that her heel hurt. The nurse indicated to the resident she would stop. RN 24 indicated to the resident that they were almost done with the dressing change, and they proceeded to complete the dressing change. The dressing change was completed at 10:20 a.m.</p> <p>During an interview, on 9/20/24 at 10:30 a.m., Licensed Practical Nurse (LPN) 25 indicated she had just given Resident 18 a pain pill. The pain pill was given after the dressing change was completed.</p> <p>During an interview, on 9/20/24 at 10:37 a.m., RN 13 indicated she had spoken to Resident 18 prior to the dressing change, and she had no complaints of pain, she had misspoken earlier and didn't mean to say the resident was pre-medicated prior to the dressing change.</p> <p>During an interview, on 9/20/24 at 11:14 a.m., Resident 18 indicated her left foot was sore and proceeded to lift it up to show which foot it was.</p> <p>Resident 18's record was reviewed on 9/18/24 at 2:19 p.m. The profile indicated the resident's diagnoses included, but were not limited to, pressure ulcer of unspecified heel (injury to skin and underlying tissue resulting from prolonged pressure on the skin).</p> <p>A significant change in status Minimum Data Set (MDS) assessment, dated 7/16/24, indicated the resident had severe cognitive deficit and had a pain assessment completed with a score of 8 out of 10.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A care plan, dated 2/2/24, indicated the resident had acute/chronic pain. Interventions included, but were not limited to, anticipate the resident's need for pain relief and respond immediately to any complaint of pain and evaluate the effectiveness of pain interventions per policy.</p> <p>A physician order, dated 7/9/24, indicated to administer Norco 10/325 mg (milligram) one tablet by mouth every 4 hours as needed for pain.</p> <p>A physician order, dated 7/10/24, indicated to monitor for pain every shift, attempt non- pharmacological interventions for pain management such as, relaxation, light touch, imagery, exercise, music, etc. every shift two times a day.</p> <p>A physician order, dated 9/13/24, indicated to apply Santyl (used to remove damaged tissue from chronic skin ulcers) external ointment 250 unit/GM (gram) to wound beds topically one time a day for healing. Apply Santyl to heel and lateral wound bed of left foot, calcium alginate to wound bed, skin prep to surrounding skin, apply telfa (non-adherent dressing) and kerlix wrap, then ace bandage.</p> <p>A pain assessment completed on 9/18/24 at 10:26 a.m., Resident 18 indicated her pain was a 6 on a numerical scale.</p> <p>A pain assessment completed on 9/20/24 at 10:30 a.m., Resident 18 indicated her pain was a 6 on a numerical scale. The Medication Administration Record (MAR) indicated Resident 18 was given a Norco at 10:30 a.m. for pain.</p> <p>A weekly pressure ulcer evaluation, dated 9/12/24, indicated the resident complained of pain during the wound debridement and dressing change.</p> <p>A weekly pressure ulcer evaluation, dated 9/5/24, indicated the resident complained of pain during the wound debridement and dressing change.</p> <p>A weekly pressure ulcer evaluation, dated 9/29/24, indicated the resident complained of pain during the wound debridement and dressing change.</p> <p>During an interview, on 9/20/24 at 10:42 a.m., the Regional Director of Clinical Services (RDCS) indicated staff would be educated on assessing for pain prior to wound dressing changes. She indicated the nurse should have stopped the dressing change on Resident 18 as soon as she complained of pain and offered her a pain pill. The dressing change then could have been completed after the medication had time to decrease her pain.</p> <p>On 9/20/24 at 11:05 a.m., the RDCS provided a document, with a revised date of March 2015, titled, Level Pain Assessment and Management, and indicated it was the policy currently being used by the facility. The policy indicated, .a. Assessing the potential for pain; b. Effectively recognizing the present of pain; c. Identifying characteristics of pain .4. It is important to recognize cognitive, cultural, familial, or gender-specific influences on the resident's ability or willingness to verbalize pain .2. Possible Behavioral Signs of Pain: a. Verbal expressions such as groaning, crying, screaming; b. Facial expressions such as grimacing, frowning, clenching of the jaw etc; .f. Guarding, rubbing, or favoring a particular part of the body</p> <p>3.1-37(a)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>35317</p> <p>Based observation, interview, and record review, the facility failed to ensure expired medications were disposed of properly for 1 of 2 medication carts and 1 of 1 medication storage rooms reviewed for medication storage (Resident 3).</p> <p>Findings include:</p> <p>1. On 9/19/24 at 9:23 a.m., the long hall medication cart contained an opened vial of Fiasp (medication used to lower blood sugar) insulin. The vial contained a handwritten name on it that indicated it was for Resident 3. The vial had an open date of 8/14/24.</p> <p>During an interview, on 9/19/24 at 9:25 a.m., Licensed Practical Nurse (LPN) 14 indicated the Fiasp insulin vial should have been discarded because it is over 30 days old. She indicated she thought the insulin was good for 30 days once opened.</p> <p>Resident 3's record was reviewed on 9/19/24 at 10:17 a.m. The profile indicated the resident's diagnosis included, but were not limited to, diabetes mellitus with hyperglycemia (a condition in which the level of glucose in the blood is higher than normal).</p> <p>A physician order, dated 2/16/24, indicated to administer Fiasp (insulin medication) injection solution 100unit/ml (milliliter). Inject per sliding scale subcutaneously (under the skin) with meals.</p> <p>Review of the September Medication Administration Record (MAR) indicated Resident 3 had received Fiasp insulin medication daily September 12 through 19, 2024.</p> <p>During an interview, on 9/19/24 at 10:30 a.m., the Regional Director of Clinical Services (RDCS) indicated insulin medication was good for 28 days once opened and the vial in the medication cart should have been disposed of since it was expired.</p> <p>On 9/19/24 at 10:30 a.m., the RDCS provided a document, dated 5/21/18, titled, Insulin Preparation and Administration, and indicated it was the current policy being used by the facility. The policy indicated, .ii. Check insulin vial to ensure correct type and expiration date</p> <p>2. On 9/19/24 at 9:47 a.m., the medication storage room contained a clear plastic bag of facility stock vaccines. The bag contained a prefilled flu vaccine syringe. The flu vaccine contained a label with an expiration date of 6/30/24.</p> <p>During an interview, on 9/19/24 at 9:50 a.m., Licensed Practical Nurse (LPN) 14 indicated the flu vaccine should have been discarded because it was expired.</p> <p>During an interview, on 9/19/24 at 10:00 a.m., the Director of Nursing (DON) indicated the flu vaccine should have been discarded because it was expired, and she was not sure why it was not noticed by the pharmacy when they had completed their audits.</p> <p>(continued on next page)</p>		

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F 0761  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 9/19/24 at 10:00 a.m., the RDCS provided a document with a revised date of April 2007, titled, Storage of Medications, and indicated it was the policy currently being used by the facility. The policy indicated, .4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed  3.1-25(o)		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49068</p> <p>Based on observation and interview, the facility failed to ensure facial hair restraints were used for 2 of 2 kitchen observations.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 9/16/24 at 10:18 a.m., the Dietary Manager (DM) was observed to go into all areas of the kitchen, including the food storage and food preparation areas. He was observed to have facial hair, a visible mustache, without a hair restraint.</p> <p>During a kitchen observation on 9/19/24 at 11:00 a.m., the DM was observed in the food preparation area of the kitchen preparing puree food items. He was observed to have facial hair, a visible mustache, without a hair restraint.</p> <p>During an interview on 9/19/24 at 11:15 a.m., the DM indicated that they had facial hair coverings, but they were located downstairs. Staff were not required to wear facial hair coverings unless they had a full beard. He thought that if they only had a mustache, they were not required to wear facial hair coverings.</p> <p>On 9/19/24 at 11:36 a.m., the DM was observed in the kitchen checking food temperatures in the food preparation area, he was observed to have facial hair, a visible mustache, without a hair restraint.</p> <p>On 9/19/24 at 1:17 p.m., the Administrator (ADM) provided a policy with a revised date of 12/16/21, titled, Associate Conduct and Dress Code, and indicated it was the policy currently being used by the facility. The policy indicated, .Hair Restraints/Jewelry/Nail Polish - Mustaches can't extend more than half an inch from the corner of the mouth, below the jaw line. The lower lip must be visible when the mouth is closed. Dietary staff must wear hair restraints on their head and may need to wear facial coverings if the facial hair is long enough that may get into the food .The Food and Nutrition Services associates wear a hair covering, which covers all unpinned hair. This includes long facial hair</p> <p>3.1-21(i)(3)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>34525</p> <p>Based on record review and interview, the facility failed to ensure post dialysis (a medical procedure that removes waste products and excess fluid from the blood when the kidneys are no longer able to function properly) vital signs were documented for 1 of 1 residents reviewed for dialysis (Resident 13), and failed to ensure the administration of medications had been documented in the medication administration records (MAR) for 4 of 12 residents MARs reviewed (Resident 25, 2, 10, and 12).</p> <p>Finding includes:</p> <p>1. Resident 13's record was reviewed on 9/19/24 at 9:14 a.m. The profile indicated the resident's diagnoses included, but were not limited to, stage 4 chronic kidney disease (a severe stage of kidney disease that occurs when the kidneys are damaged and can't filter waste from the blood as well as they should) and dependence on renal dialysis.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 7/10/24 indicated the resident had no cognitive deficit and received dialysis services.</p> <p>A care plan, dated 4/29/21 and revised on 11/10/22, indicated the resident had end-stage renal disease (final stage of chronic kidney disease) and required dialysis.</p> <p>A physician's order, dated 1/26/24, indicated the resident was to receive dialysis treatment on Monday, Wednesday, and Friday.</p> <p>Review of the resident's dialysis communication forms, dated 4/22/24 to 9/18/24, indicated the pre and post dialysis (return to the facility) vital signs were to be completed and documented. The forms indicated the following:</p> <p>a. The April 2024 dialysis communication forms lacked documentation that the post dialysis vital signs had been obtained on 4/22/24, 4/24/24, and 4/26/24.</p> <p>b. The May 2024 dialysis communication forms lacked documentation that the post dialysis vital signs had been obtained on 5/1/24, 5/3/24, 5/27/24, 5/29/24, and 5/31/24.</p> <p>c. The June 2024 dialysis communication forms lacked documentation that the post dialysis vital signs had been obtained on 6/5/24, 6/7/24, 6/10/24, 6/12/24, 6/14/24, 6/17/24, 6/19/24, 6/24/24, and 6/28/24.</p> <p>d. The July 2024 dialysis communication forms lacked documentation that the post dialysis vital sign had been obtained on 7/3/24, 7/5/24, 7/8/24, 7/10/24, and 7/12/24.</p> <p>e. The September 2024 dialysis communication forms lacked documentation that the post dialysis vital signs had been obtained on 9/4/24, 9/6/24, 9/13/24, 9/16/24, and 9/18/24.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview, on 9/19/24 at 1:21 p.m., the Regional Director of Clinical Services (RDCS) indicated she had reviewed all dialysis communication documents scanned into the resident's electronic medical record and could not see where the post dialysis vital signs had been completed on the documents. It was the expectation that the vital signs would be taken when the resident returned to the facility from dialysis.</p> <p>On 9/19/24 at 2:12 p.m., the RDCS provided a document, dated 1/10/18, titled, Hemodialysis, and indicated it was the policy currently being used by the facility. The policy indicated, .Post-dialysis: 1. If pre/post dialysis vital signs not obtained by the dialysis center before and after the treatment, obtain the resident vitals</p> <p>2. Resident 25's record was reviewed on 9/18/24 at 8:50 a.m. The profile indicated the resident's diagnoses included, but were not limited to, hypothyroidism (a condition where the thyroid gland in the neck doesn't produce enough thyroid hormone), essential hypertension (high blood pressure), and gastro-esophageal reflux disease (GERD- a condition that occurs when stomach contents flow backward into the esophagus, or food pipe).</p> <p>Review of the resident's August 2024 and September 2024 medication administration records (MARs) indicated the following:</p> <p>A physician's order, dated 7/1/24, indicated to administer one 20 milligram (mg) delayed release capsule of omeprazole (medication to prevent GERD) by mouth one time a day. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m., on 8/11/24, 8/12/24, and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m., on 9/11/24. The record lacked documentation of a resident refusal.</p> <p>A physician's order, dated 7/1/24, indicated to administer one 50 mg tablet of metoprolol tartrate (medication to lower blood pressure) by mouth two times a day, at 5:00 a.m., and 4:00 p.m. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m., on 8/11/24, 8/12/24, and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m., on 9/11/24. The record lacked documentation of a resident refusal.</p> <p>A physician's order, dated 7/9/24, indicated to administer one 175 microgram (mcg) tablet of levothyroxine sodium (medication to increase thyroid hormone) tablet by mouth one time a day. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m., on 8/11/24, 8/12/24, and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m., on 9/11/24. The record lacked documentation of a resident refusal.</p> <p>49068</p> <p>3. A record review for Resident 2 was conducted on 9/18/24 at 11:16 a.m. The profile indicated the resident diagnoses included, but were not limited to, hyperlipidemia (too much fatty substance in the blood), type 2 diabetes mellitus (the body doesn't produce enough insulin or doesn't use insulin properly, resulting in high levels of glucose in the blood), hypothyroidism thyroid [gland in the neck] does not create and release enough thyroid hormone into the bloodstream), generalized edema (swelling), iron deficiency anemia (a condition that occurs when the body doesn't have enough iron to produce healthy red blood cells).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Oak Village		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's August 2024 and September 2024 medication administration records (MARs) indicated the following:</p> <p>a. A physician's order, dated 11/2/21, indicated to administer fenofibrate micronized (lowers fatty substance content in the blood [cholesterol]) capsule, 134 milligrams (mg), give one capsule by mouth one time a day at 5:00 a.m. for diagnosis of hyperlipidemia. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/5/24 and 9/11/24. The record lacked documentation of resident refusal.</p> <p>b. A physician's order, dated 11/2/21, indicated to administer ferrous sulfate (used to replace iron in the blood) 325 (65Fe) mg, give one tablet by mouth one time a day at 5:00 a.m. for diagnosis of iron deficiency anemia. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/5/24 and 9/11/24. The record lacked documentation of resident refusal.</p> <p>c. A physician's order, dated 1/11/23, indicated to administer hydrochlorothiazide (reduces the amount of water in the body [water pill]) 12.5 mg, give one tablet by mouth one time a day at 5:00 a.m. for diagnosis of generalized edema. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/5/24 and 9/11/24. The record lacked documentation of resident refusal.</p> <p>d. A physician's order, dated 5/11/24, indicated to administer synthroid (replaces thyroid hormone in the blood) 112 micrograms (mcg), give one tablet by mouth one time a day at 5:00 a.m. for diagnosis of hypothyroidism. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/5/24 and 9/11/24. The record lacked documentation of resident refusal.</p> <p>e. A physician's order, dated 4/5/22, indicated to administer metformin hydrochloride (reduces glucose [sugar] in the blood) 850 mg, give one tablet by mouth two times a day at 5:00 a.m. for diagnosis of type 2 diabetes mellitus without complications. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/5/24 and 9/11/24. The record lacked documentation of resident refusal.</p> <p>4. A record review was conducted for Resident 10 on 9/20/24 at 11:21 a.m. The profile indicated the resident diagnoses included, but were not limited to, multiple sclerosis (a chronic disease that affects the central nervous system, including the brain and spinal cord), muscle spasms (involuntary contractions of a muscle), vitamin D deficiency (body does not produce enough vitamin D), and constipation (difficulty passing stool, can be painful).</p> <p>Review of the resident's August 2024 and September 2024 medication administration records (MARs) indicated the following:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Oak Village		STREET ADDRESS, CITY, STATE, ZIP CODE 200 W Fourth St Oaktown, IN 47561	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. A physician's order, dated 11/2/21, indicated to administer aspirin (used for pain relief and to thin blood to prevent clots) 81 milligrams (mg), give one tablet by mouth one time a day at 5:00 a.m. for prophylactic use. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/11/24. The record lacked documentation of resident refusal.</p> <p>b. A physician's order, dated 9/10/24, indicated to administer docusate sodium (stool softener) 100 mg, give one capsule by mouth one time a day at 5:00 a.m. for diagnosis of constipation. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/11/24. The record lacked documentation of resident refusal.</p> <p>c. A physician's order, dated 4/27/24, indicated to administer Mayzent (used to treats multiple sclerosis symptoms) 1 mg, give one tablet by mouth one time a day at 5:00 a.m. for diagnosis of multiple sclerosis. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/11/24. The record lacked documentation of resident refusal.</p> <p>d. A physician's order, dated 5/29/21, indicated to administer vitamin D (supplemental vitamin), give one tablet by mouth one time a day at 5:00 a.m. for diagnosis of vitamin D deficiency. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/11/24. The record lacked documentation of resident refusal.</p> <p>e. A physician's order, dated 7/9/24, indicated to administer Zanaflex (muscle relaxer that treats muscle spasms) 2 mg, give one capsule by mouth two times a day at 5:00 a.m. for diagnosis of muscle spasms. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/11/24. The record lacked documentation of resident refusal.</p> <p>35317</p> <p>5. Resident 12's record was reviewed on 9/17/24 at 3:04 p.m. The profile indicated the resident diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), pneumonia (infection that inflames air sacs in one or both lungs which may fill with fluid), hypertension (high blood pressure), and complete traumatic amputation at knee level, left lower leg (severe injury that results in the complete loss of the lower leg below the knee).</p> <p>Review of the resident's August 2024 and September 2024 medication administration records (MARs) indicated the following:</p> <p>a. A physician's order, dated 8/15/24, indicated to administer lisinopril (blood pressure lowering medication) 20 mg (milligram) by mouth one time a day. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/5/24 and 9/11/24. The record lacked documentation of resident refusal.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Oak Village		STREET ADDRESS, CITY, STATE, ZIP CODE 200 W Fourth St Oaktown, IN 47561	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. A physician's order, dated 8/15/24, indicated to administer vitamin c (water-soluble vitamin found in citrus and other fruits, berries and vegetables) 500 mg by mouth one time a day. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/5/24 and 9/11/24. The record lacked documentation of resident refusal.</p> <p>c. A physician's order, dated 8/15/24, indicated to administer zinc (supplement medication) 50 mg by mouth one time a day. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/5/24 and 9/11/24. The record lacked documentation of resident refusal.</p> <p>d. A physician's order, dated 8/15/24, indicated to administer gabapentin (medication to treat nerve pain) 300 mg by mouth two times a day. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24. The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/5/24 and 9/11/24. The record lacked documentation of resident refusal.</p> <p>e. A physician's order, dated 8/14/24, indicated to administer Zanaflex (medication to treat muscle spasms) 4 mg by mouth three times a day. The August 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 8/24/24 and 8/31/24.</p> <p>The September 2024 MAR lacked documentation of the medication having been administered at 5:00 a.m. on 9/5/24 and 9/11/24. The record lacked documentation of resident refusal.</p> <p>During an interview, on 9/18/24 at 9:54 a.m., the Regional Director of Clinical Services (RDCS) indicated the 5:00 a.m. medications should have been documented by the night shift nurse after the administration of the medication. RDCS indicated the night shift nurse was not completing her documentation, and she would be educated on the policy.</p> <p>During an interview, on 9/19/24 at 8:57 a.m., Licensed Practical Nurse (LPN) 14 indicated medications should be documented by the nurse as soon as they are administered. If a resident refused medications, then it would be documented as a refusal.</p> <p>On 9/18/24 at 9:50 a.m., the RDCS provided a document, dated 5/21/18, titled, Medication Administration General Guidelines, and indicated it was the policy currently being used by the facility. The policy indicated, . 2. Documentation a. Documentation is completed on the MAR/eMAR (electronic) immediately after medication(s) ingested by resident and completed by licensed personnel who administer the medication(s) i. Initial paper MAR or electronically sign eMAR ii. Initials should be verified with a full signature with initials on the MAR or a master signature log b. After medication administration is completed, licensed personnel reviews the MAR/eMAR to ensure all necessary does were administered and documented i. Do not report off shift without ensuring documentation is complete</p> <p>3.1-48(a)(3)</p>		