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	12/22/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement resident's plan of care based on current status for 1 of 1 resident reviewed for pressure ulcers, 3 of 5 residents reviewed for accidents, and 1 of 5 residents reviewed for unnecessary medications. A resident lacked a care plan for a current stage 3 pressure ulcer, lacked a care plan for behavior of cannabis smoking, lacked a care plan for antiplatelet medication, and not following fall interventions. (Resident 28, Resident 9, Resident 1, Resident 30, Resident 5)Findings include:1. During an observation on 12/18/25 at 10:48 A.M., Resident 5 was observed in the common area by the nurses' station in his wheelchair. The facility failed to have any activities available to the resident while seated in the wheelchair. During an observation on 12/18/25 at 11:36 A.M., Activities Assistant 4 pushed Resident 5 to the dining room to eat. Multiple residents entered the dining room after Resident 5. On 12/16/25 at 1:29 P.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and anxiety disorder. During an observation of care on 12/22/25 at 10:03 A.M., Certified Nurse Aide (CNA) 2 and CNA 3 transferred Resident 5 from his bed to the wheelchair with a lift. At that time, CNA 2 indicated there was not a non-stick layer between the cushion and the wheelchair, and she was unsure if there should have been. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/10/25, indicated severe cognitive impairment and was dependent on staff with toileting, bathing, bed mobility, and transfers. Resident 5's current care plan included, but was not limited to, The resident is at risk for falls with and without injury. Current interventions on the falls care plan included, but were not limited to, the following - Staff will transfer the resident to the dining room last for meals, start date 11/27/25 - While in a wheelchair, a rolling table with resident-focused activities in close proximity, start date, 12/9/25. - Dycem (non-skid layer) to wheelchair, start date 12/5/25 During an interview on 12/19/25 at 2:18 P.M., the Director of Nursing (DON) indicated all care plan interventions should be followed. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d 2. On 12/21/25 at 9:12 P.M., Resident 1's clinical record was reviewed. Diagnoses included diabetes mellitus type II, anxiety, and peripheral vascular disease. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/24/25, indicated Resident 1 was cognitively intact and taking an antiplatelet medication. Physician's Orders included, but were not limited to, the following: Aspirin 81 milligram (mg) tablet, give one tablet by mouth once daily for peripheral vascular disease, ordered 3/16/25 The clinical record lacked a current antiplatelet care plan. 3. On 12/16/25 at 10:47 A.M., Resident 30 was observed sitting in the common area at the nurse's station in a pedal Broda chair wearing regular grey socks. On 12/21/25 at 9:47 P.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, stroke, and anxiety. The most recent significant change MDS assessment, dated 11/13/25, indicated Resident 30's cognition was severely impaired, substantial to maximum assist of staff (staff performs over half the effort) to put footwear on and off, and dependent on staff for transfers. Resident 30 had two falls without injury since the prior assessment. A current Falls Care Plan, last revised 11/18/25, included an intervention to ensure that the resident was wearing appropriate footwear, such as non-skid socks, when ambulating or mobilizing in w/c, initiated 7/1/25 4. On 12/21/25 at 10:28 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, Multiple Sclerosis, pain in bilateral legs, and tobacco dependence. The most recent quarterly mds assessment indicated Resident 9 was cognitively intact and dependent on staff for toileting, showers, and transfers. Progress notes included, but were not limited to, the following: On 10/26/25 at 2:46 P.M., Nursing Note: it was reported to this nurse that this resident and another resident (male) were at the back door of the facility smoking marijuanavape pen, this nurse and a coworker nurse approached residents, a heavy marijuana smell was noted, asked this resident, and was handed a vape pen by the resident, the administrator was notified by staff. On 12/10/25 at 10:40 A.M., Nursing Note: was reported to this nurse by another staff member that a resident and a male resident were at the back door of the facility smoking. This nurse went to assess and noted a strong smell of pot. The nurse questioned the residents, and the male denied having one. The female resident surrendered a vape pen. This was reported to the Director of Nursing (DON). The clinical record lacked a plan of care for the behavior of cannabis smoking. During an interview on 12/22/25 at 9:20 A.M., the Social Services Director (SSD) indicated the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident should be care planned for smoking cannabis behavior; it must have been missed. During an interview on 12/22/25 at 10:46 A.M., Licensed Practical Nurse (LPN) 10 indicated that nursing staff should develop care plans on admission, and then the MDS Coordinator should be reviewing after that. She indicated residents should have a care plan for medications they are on, staff should follow the interventions on the care plans, and behaviors should be included in care plans as well. 5. On 12/16/25 at 1:41 P.M., Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and dementia. The most recent quarterly Minimum Data Set (MDS) assessment, dated 12/4/25, indicated no cognitive impairment and dependent on staff with toileting, bathing, bed mobility, and transfers. Resident 28 currently had three stage 3 pressure ulcers. Physician orders included, but were not limited to: Coccyx: Wound cleanser and triad paste, leave open to air twice a day and every 2 hours as needed, dated 12/15/25. Resident 28 returned from a hospital stay on 11/28/25 with a stage 3 pressure ulcer to the right buttock that was first identified and assessed on 12/1/25. The most recent evaluation, dated 12/15/25, indicated right buttock stage 3 pressure ulcer measuring 2.7x2.3x0.1 (centimeters) with treatment orders for wound cleanser, triad paste, and open to air. Resident 28's clinical record lacked a specific care plan for the right buttock stage 3 pressure ulcer. On 12/18/25 at 9:00 A.M., Registered Nurse (RN) 5 indicated resident care plans should be specific and reflect current status. She indicated residents should have in place a different care plan for each pressure area. On 12/20/25 at 8:14 A.M., the Administrator provided a current Care Plan policy, last revised 9/2022, that indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. 3.1-35(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure resident care plans were revised to reflect current status for 1 of 1 residents reviewed for pressure ulcers and 3 of 5 residents reviewed for unnecessary medications. A resident's pressure ulcer care plan had not been discontinued when the area healed, resident's care plans reflected current use of a discontinued medications, a fall care plan was not revised to include current interventions, and a current diagnosis of shingles and pneumonia that were no longer active (Resident 28, Resident 4, Resident 30, Resident 1)Findings include:1. On 12/21/25 at 9:12 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, anxiety, and peripheral vascular disease. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/24/25, indicated Resident 1 was cognitively intact, on an antibiotic, and not taking an anticoagulant. Physician Orders included, but were not limited to, the following: Eliquis 2.5 milligram (mg) tablet (anticoagulant), give one tablet by mouth two times a day, discontinued 3/16/25Augmentin 875-125 mg tablet (antibiotic), give one tablet by mouth two times a day for pneumonia for 5 Days, ordered 11/20/25 and discontinued 11/25/25 Current care plans included, but were not limited to, the following: An Anticoagulant Care Plan for Eliquis was last revised 2/13/25. A care plan for shortness of breath related to pneumonia, initiated and last revised 11/21/25, included, but was not limited to, an intervention to administer Augmentin as prescribed for pneumonia. 2. On 12/21/25 at 9:47 P.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, stroke, and anxiety. The most recent significant change MDS assessment, dated 11/13/25, indicated Resident 30's cognition was severely impaired, substantial to maximum assist of staff (staff performs over half the effort) to put footwear on and off, and dependent on staff for transfers. Resident 30 had two falls without injury since the prior assessment, and Resident 30 was not taking an anticonvulsant. Physician's Orders included, but were not limited to, the following: Depakote 125 mg tablet (anticonvulsant), give one tablet by mouth two times a day, discontinued 8/19/25 Current care plans included one for anticonvulsant use was initiated and last reviewed on 8/20/25. A current Falls Care Plan, last revised 11/18/25, included, but was not limited to, the following interventions: antiroll backs on w/c, initiated 10/22/25 The resident needs to be evaluated for, and supplied (Specify: appropriate adaptive equipment or (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	devices as needed). Re-evaluate (FREQ) and as needed for continued appropriateness and to ensure the least restrictive device or restraint, initiated 11/21/25 Progress notes included, but were not limited to, the following: On 11/26/25 at 1:51 P.M., Interdisciplinary Team (IDT) Note: met to discuss the resident's fall on 11/20/2025. RCA is dementia, impulsivity, and end-of-life care. The resident was immediately assessed and placed by nurse's station to increase monitoring. Intervention per team: providing the resident with a Peddle Broda chair per therapy. The resident is tolerating well with no additional falls. Will continue to monitor for changes in condition. During an interview on 12/22/25 at 10:46 A.M., Licensed Practical Nurse (LPN) 10 indicated care plans should be updated quarterly and as needed by the MDS Coordinator. Resident 1 should not have a care plan for Eliquis, and Resident 30 should not have one for Depakote because they were not currently taking the medications. Resident 30 was moved to a peddle Broda chair, and looking over the current falls care plan, the interventions were not revised to reflect the peddle Broda chair because the resident was no longer in a wheelchair. 3. On 12/16/25 at 1:27 P.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and depression. The most recent significant change Minimum Data Set (MDS) assessment, dated 11/18/25, indicated a severe cognitive impairment and dependent on staff with toileting, bathing, bed mobility and transfers. Physician orders included, but were not limited to: Famciclovir (antiviral) oral tablet 500mg (milligrams) three times a day for herpes zoster (shingles) for 7 days, dated 11/18/25 through 11/25/25. Keep areas on lower back (herpes zoster) covered with a dry dressing and change daily, dated 11/18/25 through 11/24/25. Lovenox (anticoagulant) infection 40mg/0.4ml (milliliters), inject one time a day for 28 administrations, dated 11/12/25 through 12/6/25. Resident 4's clinical record included, but was not limited to, a current care plan for anticoagulant use (Lovenox), initiated and last revised 11/12/25. Resident 4's clinical record included, but was not limited to, a current care plan for an active shingles diagnosis, initiated and last revised 11/19/25. Resident 4's December medication administration record (MAR) indicated the last dose of Lovenox was administered on 12/6/25. Resident 4's clinical record did not indicate a current diagnosis of shingles. The most recent progress note that indicated shingles was a skilled nursing note, dated 11/25/25. On 12/22/25 at 11:08 A.M., Licensed Practical Nurse (LPN) 10 indicated Resident 4 did not currently (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have an active diagnosis of shingles. 4. On 12/16/25 at 1:41 P.M., Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and dementia. The most recent quarterly Minimum Data Set (MDS) assessment, dated 12/4/25, indicated no cognitive impairment and dependent on staff with toileting, bathing, bed mobility, and transfers. Resident 28 currently had three stage 3 pressure ulcers. Current care plans indicated, but were not limited to, a bilateral buttock unstageable pressure ulcer initiated and last revised 10/13/25. Resident 28's wound evaluations indicated a bilateral buttock unstageable pressure ulcer identified 10/9/25 and healed 11/6/25. On 12/28/25 at 9:00 A.M., Registered Nurse (RN) 5 indicated resident care plans should be specific and reflect current status. On 12/20/25 at 8:14 A.M., the Administrator provided a current Care Plan policy, last revised 9/2022, that indicated Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 3.1-35(a) 3.1-35(d)(2)(B)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and comfortable environment for all residents for 3 of 3 random observations. The resident's oxygen tubing was dragging on the ground, the urinary catheter bag and tubing were dragging on the floor, and clean linens were carried against a staff member's uniform shirt. (Resident 4, Laundry 9, Resident 23)Findings include: 1. On 12/11/25 at 11:57 A.M., Resident 23 was observed propelling himself in his wheelchair down the hallway with a urinary catheter tube dragging under the resident's black shoe and hitting the floor at times. On 12/17/25 at 11:15 A.M., Resident 23 was observed in the common area by the nurse's station in a wheelchair with a urinary catheter bag dragging the floor under the wheelchair. Two nursing staff members walked past the resident, and then the Activity Director wheeled him to the front activity room, continuing to drag the catheter bag on the floor. The resident continued sitting in the activity room with his catheter bag resting on the floor. On 12/18/25 at 11:26 A.M., Resident 23 was observed propelling self in his wheelchair down the hallway to the dining room with his urinary catheter bag dragging the floor and the bottom of his black shoes hitting the tubing. On 12/17/25 at 2:34 P.M., Resident 23's clinical record was reviewed. Diagnoses included, but were not limited to, retention of urine and hemiplegia and hemiparesis affecting the left non-dominant side following a stroke. The most recent quarterly Minimum Data Set (MDS) assessment, dated 10/24/25, indicated Resident 23 was cognitively intact, had an indwelling catheter, and was totally dependent on staff for transfers and toileting. During an interview on 12/19/25 at 1:15 P.M., the Director of Nursing (DON) and Regional Clinical Support indicated a urinary catheter bag should be hung on the back of the wheelchair so off the floor, and staff should notify the nurse if they observed the bag or tubing dragging the floor so she could fix it. 2. On 12/17/25 at 10:01 A.M., Laundry 9 was observed taking clean linen from the linen cart and placing it into the linen closet. Laundry 9 gathered the clean linen from the cart, stood up placing the linen against her uniform top, then placed the linen into the linen closet. 3. On 12/17/25 at 11:17 A.M., Resident 4 was observed sitting at the end of the hallway with oxygen on. The oxygen tubing was resting on the floor. Certified Nurse Aide (CNA) 7 was observed to wheel Resident 7 from the end of the hallway into the front activity room. Resident 4 was then observed sitting in a wheelchair in the activity room with oxygen tubing still resting on the floor and lying against the inside right wheel of the wheelchair. On 12/19/25 at 1:15 P.M., the Director of Nursing (DON) indicated that if oxygen tubing is observed dragging or resting on the floor, staff would be expected to pick it up and change it out. At that time, she indicated staff were also expected to carry clean linen away from the body so it did not rub against staff uniform tops. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/22/25 at 10:22 A.M., Registered Nurse (RN) 17 indicated residents were supposed to have their oxygen tubing coiled and stored in the bag that was hanging on the handle of the wheelchair so it did not drag on the ground. On 12/20/25 at 8:14 A.M., the Administrator provided a current Respiratory Therapy policy, last revised 11/2011, that indicated to follow infection control practices with oxygen tubing. On 12/20/25 at 8:14 A.M., the Administrator provided a current Linen policy, last revised 1/2014, that indicated . provide a process for the safe and aseptic handling, washing, and storage of linen . Separate soiled and clean linen at all times . Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination . On 12/22/25 at 10:07 A.M., a current Urinary Catheter Care Policy, last revised August 2022, indicated . use aseptic technique when handling or manipulating the drainage system. Be sure the catheter tubing and drainage bag are kept off the floor . 3.1-18 (b)(1) 3.1-19(g)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure transportation was provided for a resident to get to her neurologist appointments for 1 of 2 residents reviewed for transportation. A resident receiving Botox injections for her Multiple Sclerosis (MS) missed two appointments due to not having transportation. (Resident 9)Finding includes:During an interview on 12/15/25 at 10:44 A.M., Resident 9 indicated her legs hurt bad. Her last neurologist appointment was cancelled by the facility because of transportation issues and now she had to wait until February to get her Botox injection for her MS. On 12/21/25 at 10:28 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, MS, diabetes mellitus type II, and pain in bilateral lower legs. The most recent quarterly Minimum Data Set (MDS) assessment, dated 10/15/25, indicated Resident 9 was cognitively intact and dependent on staff for toileting, showering, and transfers. Current Physician's Orders included, but were not limited to, neurologist appointment with: (provider name), (Provider Address) 2/2/26 at 11:00 A.M. A current Impaired neurological function related to MS care plan, last revised 8/13/25, included an intervention to assist with transfer to follow up neurology appointments. Progress notes included, but were not limited to, the following notes:On 11/21/25 at 2:39 P.M., Nursing Note: contacted [provider name] concerning reschedule appointment for Botox. Left message to return call. On 11/22/25 at 8:10 A.M., Medication Administration Note: resident complains of leg pain due to not getting her Botox injection. On 11/24/25 at 10:15 P.M., Nursing Note: left a voicemail for [provider name] office to return my call. Resident needs an appointment for Botox injection. During the resident council meeting on 12/17/25 at 10:00 A.M., residents indicated the facility used to have their own bus for transportation but they don't anymore and sometimes getting to appointments was a challenge. During an interview on 12/22/25 at 10:46 A.M., Licensed Practical Nurse (LPN) 10 indicated Resident 9 gets her Botox injections every 3-4 months. The nursing staff was responsible for scheduling resident appointments and there was a Scheduler who was in charge of coordinating transportation from the facility to the appointment and going with the resident's, if needed. She was on vacation during the survey period. LPN 10 indicated she had to reschedule the resident's appointment because transportation was not set up.During an interview on 12/22/25 at 1:50 P.M., Resident 9's neurologist's office indicated her last appointment was 8/21/25, and she had a Botox injection at that time. Her November appointment was rescheduled by the facility due to lack of transportation from facility to the appointment. She indicated Resident 9 should have Botox injection every 3 months. February was the first available appointment to get the resident back in for an injection.On 12/22/25 at 1:00 P.M., a current policy for transporting residents was requested and was not provided during the survey period.3.1-3(a)3.1-37(b)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview, and record review, the facility failed to ensure behavior monitoring for 1 of 1 residents reviewed for behavior concerns. A resident's behaviors were not monitored, tracked, or treated leading to an escalation of behaviors. (Resident 2)Finding includes:On 12/17/25 at 11:28 A.M., Resident 2 was observed sitting in a wheelchair in the front activity room participating in an activity. On 12/16/25 at 1:32 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, depression, and bipolar disorder. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/18/25, indicated no cognitive impairment and no behaviors. Resident 2's clinical record lacked a physician's order to monitor behaviors. A behavior monitoring care plan, initiated 6/23/23 and last revised 7/17/25, indicated behaviors related to medication changes in 2/2023 as well as a roommate change in 6/2023. A behavior care plan, initiated and last revised 3/26/24, indicated behaviors related to threats of self-harm and suicide. Behavior progress notes included, but were not limited to, the following:4/8/25 at 6:08 P.M. Resident was involved in a verbal altercation with another resident. The resident remained upset after separated from the other resident. The charge nurse was notified. The clinical record lacked documentation of notification to the physician or psychiatric provider. 8/3/25 at 1:40 P.M. Resident was involved in a verbal altercation with another resident. The resident yelled, cursed, and threatened to hit the other resident, then threatened to hit the nurse. The resident was removed from the area. The clinical record lacked documentation of notification to the physician or psychiatric provider. 12/13/25 at 9:45 A.M. Resident was involved in a verbal altercation with another resident. Residents are cursing at each other. The resident swung a fist but did not make contact with the other resident. Resident placed on 15-minute checks. Notification was made to the Administrator and Director of Nursing (DON). The clinical record lacked documentation of notification to the physician or psychiatric provider. The clinical record lacked Interdisciplinary (IDT) notes related to behaviors for the last 12 months. A care plan conference dated 6/12/25 indicated no behaviors noted. A care plan conference dated 9/11/25 indicated no concerns with behaviors. A care plan conference dated 11/24/25 indicated no noted behaviors and no behavior concerns. A psychiatric visit note, dated 4/16/25, indicated no behaviors reported by facility staff. On 12/22/25 at 9:04 A.M., the Social Services Director (SSD) indicated she was made aware of resident behaviors by reviewing the treatment administration record (TAR) when there is an order to monitor behaviors, or reviewing the behavior log binder that was located at the nurses' station. She indicated all behaviors were discussed in the morning meeting within 48 hours of the behavior, and any new interventions would be added to the plan of care at that time. She indicated that behaviors were also discussed at care plan conferences. She indicated she had just read about a behavior of several loud outbursts from Resident 2 that occurred over the weekend (12/20/25) and would be discussed later that day. She indicated she was unaware of any other behaviors from Resident 2, as she has not had any behaviors in a while. On 12/22/25 at 9:24 A.M., the SSD indicated Resident 2 was in need of a behavior monitoring care plan. On 12/22/25 at 10:53 A.M., Certified Nurse Aide (CNA) 7 indicated that when a resident displayed a behavior, the aides would notify the nurse, and the nurse would then document it. She indicated she was unaware of any current behaviors from Resident 2. She indicated Resident 2 had a history of name-calling, but behaviors had never been physical. On 12/22/25 at 10:56 A.M., Licensed Practical Nurse (LPN) 10 indicated behaviors were documented as a behavior note. She indicated some residents had behavior monitoring in the TAR from a physician's order, and nurses could document behaviors there as well. She indicated the physician, DON, Administrator, and SSD should be contacted with the resident's behaviors as well as the psychiatric provider. She indicated Resident 2 yelled and cursed a lot, attempted to smack her roommate, and threatened other residents constantly. On 12/20/25 at 8:14 A.M., the Administrator provided a current Behavior Monitoring policy, last (continued on next page)

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	12/22/2025

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 2/2025, that indicated Circumstances that warrant a behavioral assessment of a resident include . new or worsening change in status or condition . New onset or changes in behavior are evaluated and documented, regardless of the degree of risk to the resident or others . The IDT thoroughly evaluates new or changing behavioral symptoms to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition . The IDT evaluates behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develops a plan of care accordingly 3.1-37(a)3.1-43(a)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. Based on interview and record review, the facility failed to ensure pharmaceutical services were provided to meet the needs of residents for 1 of 5 residents reviewed for unnecessary medications and 1 of 2 closed records reviewed. Medications were not available to be administered as prescribed. (Resident 4, Resident 18)Findings include:1.On 12/16/25 at 1:27 P.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, status post hip surgery, dementia, anxiety, and depression. The most recent significant change Minimum Data Set (MDS) assessment, dated 11/18/25, indicated a severe cognitive impairment. Physician orders included, but were not limited to:Aspirin 81mg (milligrams), 1 capsule every 3 days, dated 11/14/25. Breo Ellipta inhalation aerosol powder 100-25mcg (micrograms)/act (actuation/puff) 1 inhalation one time a day, dated 11/12/25. Lovenox injection 40mg/0.4ml (milliliters) inject 1 dose one time a day for 28 administrations, dated 11/12/25. Resident 4's medication administration record (MAR) indicated aspirin was not administered on 11/14/25 due to family would be picking up from the pharmacy. The next administration of aspirin was on 11/17/25. Resident 4's MAR indicated Breo Ellipta was not administered on the following dates:11/12/25 not available, waiting for delivery 11/13/25 continue to wait for delivery, son is to pick up medication from the pharmacy 11/14/25 family to pick up medication from pharmacy 11/16/25 medication not delivered from the pharmacy 11/17/25 waiting on delivery from son 11/18/25 continue to wait for son to deliver 11/19/25 medication yet to be picked up at the pharmacy per family 11/22/25 not available Resident 4's MAR indicated that Lovenox was not administered on the following dates:11/14325 no supply available 11/14/25 medication not available in the facility 11/15/25 no medication in the cart or refrigerator 11/16/25 medication unavailable 11/17/25 medication unavailable, uses outside pharmacy, and family has not delivered medication Resident 4's clinical record lacked documentation of notification to the pharmacy for the request of aspirin, Breo Ellipta, or Lovenox. Resident 4's clinical record lacked notification of the lack of medications to the pharmacy, physician, Director of Nursing (DON), Administrator, or social services. On 12/22/25 at 11:08 A.M., Licensed Practical Nurse (LPN) 10 indicated there had been delays obtaining medications from the pharmacy. She indicated medications had to be ordered prior to 5 P.M. on weekdays to receive them that night. Otherwise, it would be the next day. She indicated if a medication came in late and it was to be given once a day, it may be given later and the reason documented. She indicated the physician and pharmacy should be contacted if a medication was not available in the medication cart or Emergency Drug Kit (EDK). 2. During medication administration for Resident 18 on 12/18/25 at 8:45 A.M., Registered Nurse (RN) 5 indicated the resident had been out of Vitamin D3 for a while. She indicated the provider was aware. At that time, Resident 18's medication administration record was reviewed and indicated Vitamin D3 had not been administered 12/14/25, 12/15/25, or 12/16/25 due to an order from the pharmacy. On 12/22/25 at 10:00 A.M., the Director of Nursing (DON) indicated if a medication is on hold from the pharmacy or not available for some other reason, the nurse should check the EDK to see if the medication is there. If not, either the Social Services Director (SSD) or the Human Resources (HR) person could go and pick up the medication. She indicated this could be done immediately. On 12/20/25 at 8:14 A.M., the Administrator provided a current Medication Administration policy that indicated Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders, including any required time frame. 3.1-25(a)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on the interview and record review, the facility failed to ensure its smoking policy was implemented for 2 of 2 residents reviewed for smoking. Resident's smoking evaluations were not completed quarterly. (Resident 9, Resident 1)Findings include:1. On 12/21/25 at 9:12 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, tobacco use, and peripheral vascular disease. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/24/25, indicated Resident 1 was cognitively intact and dependent on staff for transfers and toileting.Resident 1's current care plans included a Smoking Care Plan, last revised 6/19/23.The last smoking evaluation on Resident 1 was completed on 3/25/25.2. On 12/21/25 at 10:28 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, Multiple Sclerosis, pain in bilateral legs, and tobacco dependence.The most recent quarterly MDS assessment indicated Resident 9 was cognitively intact and dependent on staff for toileting, showers, and transfers.Resident 9's current care plans included a Smoking Care Plan, last revised 2/15/23.The last smoking evaluation on Resident 9 was completed on 2/21/25.During an interview on 12/22/25 at 10:46 A.M., Licensed Practical Nurse (LPN) 10 indicated that Resident 1 and Resident 9 both currently smoked at the facility. Smoking evaluations should be completed quarterly and as needed. If they were not done quarterly, they must have been missed.On 12/11/25 at 11:03 A.M., a current Smoking Policy, revised 2/13/23, was provided by the Administrator and indicated, . 7. An assessment will be completed to determine which Residents are safe and unsafe smokers and what restrictions, if any, will need to be placed on the Resident's smoking privileges. All Residents who smoke will be supervised to further ensure safety. Any smoking-related privileges, restrictions, and concerns shall be noted on the care plan, and all personnel caring for the Resident shall be alerted to these issues. 9. The facility may impose smoking restrictions on the Residents at any time if it determined that the resident cannot smoke safely with the available levels of support and supervision. Smoking aprons will be provided if determined to be necessary. 10. The staff will review the status of a Resident's smoking privileges quarterly and with significant changes .