STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155837	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villages at Oak Ridge, The	1694 Troy Road Washington, IN 47501

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to prevent falls for 1 of 3 residents reviewed for accidents. Following multiple falls, a resident care plan interventions were not in place to prevent an additional fall. (Resident C)Findings include: During record review on 2/26/25 at 11:15 A.M., Resident C's diagnoses included, but were not limited to, repeated falls, chronic pain, and depression. Resident C's most recent admission Minimal Data Set (MDS) assessment, dated 5/2/25, indicated the resident had moderate cognitive impairment, used a walker for mobilization, and had one-sided upper extremity impairment. Resident C's physician orders included but were not limited to: call light attendant to bed, check placement and function every shift (started 5/11/25).Resident C's care plan included, but was not limited to, the resident at risk for falls due to falls at home with minor injury, antidepressant medications, altered balance and coordination (started 4/29/25). Fall interventions included but were not limited to; call light attendant to bed, check placement and function every shift (started 5/9/25), call light attendant to recliner in room, check placement and function every shift (started 5/30/25), and staff to ensure resident is in bed or recliner when in room, with call light attendant in place (started 6/16/25). Resident C's progress notes included, but were not limited to:7/3/25 at 2:59 P.M. - Intra-Disciplinary Team (IDT) review of a fall that occurred on 7/3/25 at 4:15 A.M., Resident found on the floor in her room following a fall. The call light attendant was found unplugged from the wall at the time of the fall. The root cause appears to be an unassisted attempt to use the toilet, likely due to the inability to call for help. New interventions include ensuring the call light attendant is properly connected and functioning at all times.During an observation on 7/24/25 at 11:05 A.M., Resident C was sitting up in her wheelchair near the foot of the bed. Resident C's call light was hanging off of the recliner in the room on the opposite side of the bed, and another call light was in the resident's bedside table drawer near the head of the bed, out of reach. LPN 5 entered Resident C's room to administer medications to Resident C's roommate and walked past Resident C to get to the roommate's side of the room. LPN 5 then walked past Resident C as she exited the room. LPN 5 did not offer to assist the resident to her bed or recliner, where the call light attendants were placed, nor did LPN 5 place the resident's call lights in reach. During an interview on 7/24/25 at 11:10 A.M., LPN 5 indicated being unaware if Resident C had a call light attendant in place and indicated not having worked that hall recently. LPN 5 indicated that for residents with call light attendants, staff should check on the residents hourly and ensure the call light attendants are functioning every shift or as they go in and out of resident rooms.On 7/24/25 at 11:57 A.M., the Director of Nursing (DON) supplied a facility policy titled Fall Management Program Guidelines, dated 12/17/24. The policy included, [Company name] strives to maintain a hazard-free environment, mitigate fall risk factors and implement preventative measures . 4. Any orders received from the physician should be noted and carried out . 6. Nursing staff will monitor and document continued resident response and effectiveness of interventions .This citation relates to complaint 1841867.3.1-45(a)(1)

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