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	04/14/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure care and services were provided to treat pressure ulcers for 1 of 3 new admisstions reviewed for quality of care. Staff identified a new pressure ulcer but did not assess the wound or obtain new treatment orders for three days. (Resident C)Finding includes:During record review on 4/14/26 at 10:30 A.M., Resident C's diagnoses included, but were not limited to, lumbar fracture, polyneuropathy, muscle weakness, need for personal assistance with care, and cognitive communication deficit. Resident C's most recent admission Minimum Data Set (MDS) assessment, dated 3/2/26, indicated the resident had moderate cognitive impairment, was dependent for mobility, had no unhealed pressure wounds, and was at risk for developing pressure ulcers. Resident C's care plan included but was not limited to:At risk for skin breakdown due to episodes of incontinence and assistance required for mobility/positioning tasks due to decline in functional mobility (started 3/17/26).Resident has a pressure ulcer to left buttock (started 3/29/26 and revised 4/4/26). Resident C's nurses progress notes included but were not limited to:- On 3/21/26 at 12:56 P.M., upon changing resident for incontinent episode, yeast was present around Foley catheter and scrotal area. On resident's left gluteal fold shearing was noted measuring 2 cm (centimeters) (length) x 1 cm (width). Area cleansed and a house barrier cream was applied. - On 3/25/26 at 8:58 A.M., wound care nurse was informed of resident's buttocks needing to be assessed. Upon assessment it was noted that resident had MASD to gluteal fold that measured 3 cm x 4 cm. Area is red with skin sheering, edges appear to be flakes of dried skin, and scant drainage noted. Area cleansed and Mary's Magic Butt Cream applied. Wound Care will follow weekly and as needed.- On 3/29/26 at 5:42 P.M., resident complaining of pain to buttocks. An open wound with yellow slough is visible. Wound is lateral to midline of body.- On 4/1/26 at 07:24 P.M., Wound Progress Note - Left Buttock (Stage 3 Pressure Injury): Wound measures 5.02 cm x 3.14 cm. Peri-wound skin is affected by MASD. Wound bed consists of healthy granulation tissue. Edges are well-defined with epithelialization present. No slough, odor, or drainage noted. (This note including assessments was entered three days after the open area was identified)Resident Left buttock weekly wound assessments included:4/1/26 - Left buttock wound measurement 5 cm x 3.1 cmWound bed is one hundred percent granulation tissue with defined marginsRoot Cause: Resident has become immobile secondary to a back fracture and is unable to independently turn or reposition when uncomfortable. (This assessment was three days after the open area was identified)Resident C's physician orders included, but were not limited to:- Triad wound dressing three times a day, apply thin layer, topical (started 4/1/26 and discontinued 4/8/26). (The new physician order was obtained three days after the open area was identified.)- Apply Mary's Magic Butt Cream to buttocks four times a day for moisture associated dermatitis (MSAD) (started 3/27/26 and discontinued 4/1/26). During an observation on 4/14/26 at 1:00 P.M., RN 2 provided wound care to Resident C's left buttocks. The wound appeared as three separate open areas with one larger open area and two smaller open areas on the left buttock. The wound beds were pink in color and were covered with granulation tissue. Wound edges were well defined. Surrounding skin was pink in color. Resident C indicated that the wound was painful and burned during treatment. During an interview on 4/14/26 at 12:44 P.M., RN 2 indicated the nurse that initially discovered the open area to Resident C's left buttock should have (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	created a wound occurrence in the resident's record and fully completed a wound assessment with a full description of the wound and measurements. During an interview on 4/14/26 at 1:45 P.M., LPN 14 indicated that if a new wound was discovered, the nurse should open a wound event that would trigger an initial, complete assessment with measurements. The physician and wound nurse should be notified in order to obtain a new wound treatment.During an interview on 4/14/26 at 1:50 P.M., RN 2 indicated she did not believe the wound was staged correctly by a new wound care nurse and that the initial observation of yellow slough was actually the ordered topical treatment, Mary's Magic Butt Cream. On 3/2/26 the facility provided a facility policy titled, Guidelines for General Wound and Skin Care, dated 2/12/25. The policy included, .Turn/reposition residents who are immobile according to their care plan requirements . Notify wound care nurse/nurse supervisor for all new stage II - IV pressure ulcers or if you have any questions .This citation relates to Intakes 2634487 and 2695539.410 IAC (Indiana Administrative Code)16.2-3.1-40(a)(2)