STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155667	A. BUILDING 00 B. WING	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OAK GROVE CHRISTIAN RETIREMENT VILLAGE	221 W DIVISION ST DEMOTTE, IN 46310

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00433724, IN00433725, and IN00434136. Complaint IN00433724 - No deficiencies related to the allegations are cited. Complaint IN00433725 - No deficiencies related to the allegations are cited. Complaint IN00434136 - Federal/State deficiencies related to the allegations are cited at F609 and F689. Survey dates: May 13 & 14, 2024 Facility number: 010823 Provider number: 155667 AIM number: 200236630 Census Bed Type: SNF/NF: 46 SNF: 10 Residential: 27 Total: 83 Census Payor Type: Medicare: 13 Medicaid: 28 Other: 15 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/16/24.	F 0000	This Plan of Correction is submitted as this facility's credible allegation of compliance. This Plan of Correction is prepared and submitted as required by state and federal law. By submitting this Plan of Correction, Oak Grove Christian Retirement Village does not agree with the deficiencies listed in this report exist. Preparation and implementation of the Plan of Correction is done as a part of our continuous process of improvement and quality of care. Supporting documentation is uploaded for your review and we ask for a desk review of these materials to show compliance. Respectfully Submitted, Beth Ingram Director	

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

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F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to report an allegation of abuse/neglect to the Administrator of the facility, for 1 of 1 resident with an allegation of abuse/neglect voiced by a family member. (Resident B) Finding includes:	F 0609	Step One: The allegation was investigated and reviewed with the investigating surveyor and found that the allegation did not constitute neglect. Step Two: Nurses notes from the	05/30/2024

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	Resident C's record was reviewed on 5/13/24 at 8:09 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 2/17/24, indicated the resident had a moderately impaired cognitive status, had no behaviors, and was dependent for eating. A Care Plan, dated 7/21/23, indicated a risk for falls. An intervention, dated 7/21/23, indicated no hot drinks were to be served in the room or with meals. A Nurse's Progress Note, dated 5/8/24 at 4:29 a.m., indicated Agency LPN 1 was summoned to the resident's room by a CNA and observed the resident in bed with reddened skin to the upper abdomen and underneath the left breast. The areas were tender to touch and the resident grimaced and winced when the area was touched. Resident B had indicated she had spilled her coffee while trying to take a drink. A cold compress was applied to the affected area. The Nurse Practitioner was notified and the Responsible Party had not answered the phone. A Nurse's Progress Note, dated 5/8/24 at 6:18 a.m., indicated Agency LPN 1 had placed a call to the Responsible Party and informed him of the spilled coffee incident and thee reddened skin on the upper abdomen and underneath the left breast. The Responsible Party then informed the nurse, the resident was not to have food or drinks in the room and accused the facility of, "willful and criminal neglect." During an interview on 5/13/24 at 9:47 a.m., the		weekend were reviewed to assure that no other allegations went unreported. In addition, Nurses were interviewed to determine if an allegation was made that required reporting. None were found. Step Three: All staff were re-educated to the need to immediately call the administrator with any allegation of abuse or neglect. Step Four: The Director of Nursing or her designee will audit all nurses' notes five times weekly for six months. Results of the audit will be reported to QAPI for review. The QAPI team will recommend amendments to the plan of correction or determine need for ongoing audits.	

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	Director of Nursing (DON) indicated no investigation had been completed because there had been no redness of the skin when she observed the resident. The allegation of abuse/neglect had not been reported to the Administrator or the Indiana Department of Health (IDOH). The Responsible Party had entered the facility later that day and had not said anything to her about neglect. During an interview on 5/14/24 at 9:53 a.m., Agency LPN 1 indicated the CNA on the night shift had given a cup of hot coffee to the resident while the resident was still in bed. Agency LPN 1 was able to get a hold of the Responsible Party after the third time of calling. She reported the phone call to the day shift nurse coming on duty and the DON had called into the facility and she reported the statement to her. During an interview on 5/14/24 at 10:10 a.m., the DON indicated she had called in to the facility and the nurse had informed her about the phone call, but had not said he made an allegation of neglect. The facility abuse policy, dated 9/20/22, and identified as current by the Interim Administrator, indicated an allegation of abuse, neglect, and exploitation would be investigated immediately and all allegations were to be reported to the Administrator, state agency, adult protective services, and all other required agencies, immediately, but not later than 2 hours after the allegation was made. This citation relates to Complaint IN00434136. 3.1-28(c)			

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure adequate supervision was provided and care plan interventions were followed to prevent a fall (Resident D) and spillage of hot coffee on the skin (Resident C), for 2 of 3 residents reviewed for accidents and supervision. Findings include: 1. Resident D's record was reviewed on 5/14/24 at 8:58 a.m. The diagnoses included, but were not limited to, dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 4/22/24, indicated the resident had a severely impaired cognitive status, no behaviors, no impairments of the upper and lower extremities, was dependent for toileting, and required maximum assistance for bed mobility and transfers. She was independent with wheelchair mobility and had no falls since the last review. During an interview on 5/14/24 at 10:04 a.m., The RN MDS Nurse indicated the MDS assessment was incorrect and the resident had a fall on 2/29/24 and the MDS would be modified.	F 0689	Step One: The care plan and care sheet of the identified residents was updated to reflect current care needs. Step Two: The care plans and care sheets of all residents were reviewed for accuracy and updated as needed. Step Three: Nursing staff were educated to the importance of knowing and implementing each resident's plan of care. Step Four: Fifteen fall and accident care plans will be audited for implementation weekly for four weeks then ten the second month, then 5 monthly for the next four months. Audit results will be presented to QAPI for review. QAPI will amend the plan of correction or determine need to continue audits.	06/07/2024

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	A revised Care Plan, dated 5/4/24, indicated a risk for injuries related to falls and falls had occurred on 12/15/23, 1/29/24, 2/29/24, and 5/4/24. An intervention, dated 2/29/24, was added to the care plan that indicated she would not be left alone in her room while sitting in the wheelchair. A Nurse's Progress Note, dated 5/3/24 at 9:33 p.m., indicated RN 2 was called to the resident's room after the resident fell. Resident D was on the floor next to the bed and had hit her head and the head was bleeding. CNA 4 applied pressure to the head, the resident had not been moved, and EMS (Emergency Management Services) were notified and she was transferred to the Emergency Room (ER) for an evaluation and treatment. The resident had informed the nurse she forgot to lock her wheelchair. A Nurse's Progress Note, dated 5/4/24 at 4:29 a.m., indicated the resident returned from the ER around 4:15 a.m. with two staples in the back of the head due to a laceration. The neurological exam was stable and 30 minute safety checks were to be continued. A facility investigation of the fall, dated 5/4/24, indicated the resident forgets to lock her wheelchair when she tries to transfer. She received a 2 centimeter by 1 centimeter laceration with two staples required and had an overlying hematoma (bruising) of the lacerated area. Anti-roll back brakes were to be applied to the wheelchair. During an interview on 5/14/24 at 10:10 a.m., the Director of Nursing (DON) indicated the resident was left in her room by herself while in the wheelchair.			

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	During an interview on 5/14/24 at 10:43 a.m., QMA 3 indicated she had given the resident her pain medication and eye drops and had just left the room when her and CNA 4 heard a crash and the resident yell out. They went to her room immediately and the resident was on the floor next to her bed. The resident had said she was reaching for the TV remote on her bed and slid out of the wheelchair. The brakes on the wheelchair were no locked. The resident was in her room by herself. During an interview on 5/14/24 at 11:30 a.m., CNA 4 indicated she had been in the resident's room about 15 minutes prior to the fall. CNA 4 and QMA 3 were in the hall when they heard the crash and they both responded immediately. The resident was not moved, the nurse was notified and responded immediately. The resident had said she was reaching for her remote control on her bed. 2. Resident C's record was reviewed on 5/13/24 at 8:09 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 2/17/24, indicated the resident had a moderately impaired cognitive status, had no behaviors, and was dependent for eating. A Care Plan, dated 7/21/23, indicated a risk for falls. An intervention, dated 7/21/23, indicated no hot drinks were to be served in the room or with meals. The CNA Care Sheet, dated 4/11/23, indicated she was not to have meals, snacks, or hot drinks in her room.			

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	A Nurse's Progress Note, dated 5/8/24 at 4:29 a.m., indicated Agency LPN 1 was summoned to the resident's room by a CNA and observed the resident in bed with reddened skin to the upper abdomen and underneath the left breast. The areas were tender to touch and the resident grimaced and winced when the area was touched. Resident B had indicated she had spilled her coffee while trying to take a drink. A cold compress was applied to the affected area. A Nurse's Progress Note, dated 5/8/24 at 5:36 a.m., indicated there was no further redness to the upper abdomen and left breast. Cold compresses were continued. A Nurse Practitioner's Progress Note, dated 5/9/24 at 1:52 p.m., indicated there was no redness, swelling, pain, or visual burn of the upper abdomen and left breast. During an interview on 5/13/24 at 10:24 a.m., the Director of Nursing and Assistant Director of Nursing indicated the staff had access to the CNA Care Sheet which had the 4/11/23 intervention of no hot drinks in the room. This citation related to Complaint IN00434136. 3.1-45(a)(2) .			