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	07/11/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaints IN00400228, IN00403128, IN00406313, IN00408550 and Nursing Home and Residential Complaints IN00411197 and IN00412035. This visit included a COVID-19 Focused Infection Control Survey and a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00400228 - No deficiencies related to the allegations are cited. Complaint IN00403128 - Federal/State deficiencies related to the allegations are cited at F686, F690, F694, F757, F804, F812, and F895. Complaint IN00406313 - Federal/State deficiencies related to the allegations are cited at F558, F804, and F812. Complaint IN00408550 - No deficiencies related to the allegations are cited. Complaint IN00411197 - State deficiencies related to the allegations are cited at R0064 and R0090. Complaint IN00412035 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: July 6, 7, 10, and 11, 2023 Facility number: 010823 Provider number: 155667 AIM number: 200236630 Census Bed Type:	F 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Oak Grove Christian Retirement Village desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on, August 3, 2023. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rosemary Weeks	VP Operations	08/03/2023

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	SNF/NF: 32 SNF: 20 Residential: 34 Total: 86 Census Payor Type: Medicare: 12 Medicaid: 24 Other: 16 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/17/23.			
F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review and interview, the facility failed to accommodate the needs of residents related to the call lights being out of reach for 4 random resident observations. (Residents C, Q, P, and J) Findings include: 1. Resident C was observed on 7/6/23 at 10:23 a.m., in bed with her eyes closed. The call light was draped over the bedside dresser upper drawer toward the recliner in the room and was out of reach from the bed.	F 0558	The facility was alleged to be out of compliance by failing to accommodate the needs of residents related to call lights being out of reach for 4 random resident observations. It is the policy of this facility to accommodate the needs of residents related to the call lights being within reach. **I. <u>Specific Corrective Actions:</u>** Call lights were put in place for Residents C, Q, P, and J. Staff assigned were educated. **II. <u>Identification and correction</u>**	08/31/2023

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	Resident C's record was reviewed on 7/7/23 at 10:56 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and diabetes. The Care Plan, dated 10/14/21, indicated a risk for falls. The interventions included the call light would be kept within reach. 2. During an observation on 7/6/23 at 10:26 a.m., Resident Q was in bed. the call light was clipped to the cord on the wall behind the bed and not within reach. During an observation on 7/6/23 at 3:23 p.m., the resident was sitting in the chair in the room. The call light remained clipped to the cord on the wall behind the bed and not within reach. Nursing Employee 2 was interviewed at the time of the observation and indicated the resident would not be able to reach the call light if she needed assistance. Resident Q's record was reviewed on 7/7/23 at 6:51 a.m. The diagnoses included, but were not limited to, peripheral vascular disease. A Care Plan, dated 4/7/23, indicated a risk for injuries due to falls. The intervention included the call light would be within reach. 3. During an observation on 7/6/23 at 10:27 a.m., Resident P was lying in bed with her eyes closed. The call light was on the floor. During an observation on 7/6/23 at 3:23 p.m., the resident was lying in bed. The call light was draped over the top drawer of the bedside dresser and not within reach. Resident P searched for the call light on her nightgown and was unable to find it when asked what she would do if she needed		**of others:** All residents have the potential to be affected. Rounds were done to ensure all call lights are within reach of the residents, if a call light was found not to be within reach it was relocated so the resident could reach it. **III. Systemic Changes:** All staff were educated to ensure call lights are within reach of the resident before exiting the room. **IV. Monitoring:** Random audits will be conducted by the Administrator/designee to ensure call lights are in place weekly for 4 weeks and monthly for 5 months. May continue another 6 months if ongoing concerns are noted. Results will be reviewed during the monthly QAPI Meetings. [Attachment: Call Lights CQI Audit Tool & QA Tracking Log]	

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	help. She was unable to reach the call light on the dresser. During an interview on 7/6/23 at 3:25 p.m., Nursing Employee 2 indicated the resident was unable to reach her call light. Resident P's record was reviewed on 7/7/23 at 6:48 a.m. The diagnoses included, but were not limited to, dementia. A Care Plan, dated 12/27/22, indicated a risk for injuries due to falls. The intervention included the call light would be within reach. 4. During an observation on 7/6/23 at 10:29 a.m., Resident J was lying in bed. The bed was lowered to the floor with a floor mat on the left side of the bed. The call light was on the floor at the end of the bed. During an observation on 7/6/23 at 3:23 p.m., the resident was lying in bed. The call light remained on the floor at the end of the bed. At the time of the observation, Nursing Employee 2 indicated the resident was unable to reach the call light. Resident P's record was reviewed on 7/7/23 at 6:50 a.m. The diagnoses included, but were not limited to Alzheimer's disease. A Care Plan, dated 3/4/21, indicated a history of falls. The interventions included to ensure the call light was in reach. This Federal tag relates to Complaint IN00406313. 3.1-3(v)(1)			

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure a bowel management program was initiated for residents who had not had a bowel movement in over three days for 2 of 3 residents reviewed for a bowel management program. (Residents C and K) Findings include: 1. Resident C's record was reviewed on 7/7/23 at 10:56 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and diabetes. A Quarterly Minimum Data Set assessment, dated 4/20/23, indicated a severely impaired cognitive status, extended assistance of two staff for transfers, limited assistance of one staff for ambulation, extensive assistance of one staff for toileting, and was continent of bowel movements. A Physician's Order, dated 7/17/20, indicated bowel movements were to be monitored every shift. A Physician's Order, dated 5/4/22, indicated Milk of Magnesia (MoM), 30 cc (cubic centimeters), as needed daily for constipation.	F 0684	The facility was alleged to be out of compliance by failing to ensure a bowel management program was initiated for residents who had not had a bowel movement in over 3 days for 2 of 3 residents reviewed for a bowel management program. **I. Specific Corrective Actions:** Residents C and K were assessed, and physicians and family notified. Staff assigned were educated on bowel management programs. **II. Identification and correction of others:** A bowel audit was completed for the past 14 days and a few residents were identified as not having had a bowel movement in over 3 days. Physicians orders were followed and results were obtained and documented. **III. Systemic Changes:** All nursing staff were educated on bowel management programs and documentation of bowel	08/31/2023

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	The Treatment Administration Record, dated 6/2023, indicated a bowel movement on day shift on 6/2/23, on evening shift on 6/7/23 (4 days with a bowel movement), 6/9/23, 6/10/23, 6/15/23 (4 days without a bowel movement), 6/20/23 (4 days without a bowel movement), on night shift on 6/20/23, and on day shift on 6/26/23 (5 days without a bowel movement). The Medication Administration Record, dated 6/2023, indicated the as needed MoM was only administered on 6/2/23 in June.2. Interview with Resident K on 7/6/23 at 10:02 a.m., indicated she would have problems with her bowels sometimes and they would give her medication and prune juice, which usually worked. The record for Resident K was reviewed on 7/6/23 at 2:17 p.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, and osteoarthritis. The Quarterly Minimum Data Set (MDS) assessment, dated 4/11/23, indicated the resident was cognitively intact and always incontinent of bowel and bladder. A current care plan, updated 4/18/23, indicated the resident had a history of constipation. The interventions included, monitor and record bowel movements every shift and administer medication as ordered. The Bowel Function Point of Care Daily Charting, dated 6/2023, lacked documentation that the resident had any bowel movements from 6/7/23 through 6/11/23, 5 days since her previous bowel movement. The Treatment Administration Record (TAR),		movements. Licensed staff were educated to run the BM report q shift to observe for residents without a bowel movement in 3 days. **IV. <u>Monitoring:</u>** A bowel movement audit will be completed by the DON/designee weekly for 4 weeks and monthly for 5 months. May continue another 6 months if ongoing concerns are noted. Results will be reviewed during the monthly QAPI Meetings. [Attachment: Bowel Management CQI Audit Tool & QA Tracking Log]	

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	dated 6/2023, indicated the resident had no bowel movements from 6/7/23 through 6/11/23, 5 days since her previous bowel movement. The Physician's Order Summary, dated 7/2023, indicated an order for sennosides-docusate sodium 8.6 mg (milligrams)-50mg daily on Sunday, Tuesday, Thursday, and Saturday. Milk of Magnesia 400 mg/5 ml, 30 ml (milliliters) daily as needed for constipation. Miralax 17 grams daily as needed for constipation. The Medication Administration Record, dated 6/2023, indicated the resident had not received any PRN (as needed) Milk of Magnesia or Miralax. Interview with the ADON (Assistant Director of Nursing) on 7/6/23 at 4:33 p.m., indicated if there is no bowel movement for 3 days then staff should provide an intervention. The intervention would depend on the resident and what worked best for them. Most of the time it would be a PRN medication if they had orders for one. A facility policy titled, Bowel Elimination Management, received as current, indicated "...4. If the resident does not have a bowel movement in 3 days, resident will be offered MOM (Milk of Magnesium) daily until a bowel movement is produced. Bowel sounds should be assessed and documented q (every) shift..." This Federal tag relates to Complaint IN00412035. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity			

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	§483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure residents received pressure ulcer treatments, interventions, and nutritional supplements as ordered by the Physician, for 2 of 3 residents reviewed for pressure ulcers. (Residents E and H) Findings include: 1. Resident E's record was reviewed on 7/6/23 at 12:05 p.m. The diagnoses included, but were not limited to, sacral pressure ulcer, Parkinson's disease, and congestive heart failure. A Quarterly Minimum Data Set assessment (MDS), dated 6/30/23, indicated a moderately impaired cognitive status, extensive assistance of two staff for bed mobility, dependent on two staff for transfers, extensive care for toileting and hygiene. A stage 4 (full thickness skin loss with extensive destruction, tissue necrosis, or damage to the muscle, bone, or supporting structures) pressure ulcer was present on admission. A pressure reducing mattress, a pressure reducing cushion in the chair, nutritional interventions, and pressure ulcer care was provided.	F 0686	The facility was alleged to be out of compliance by failing to ensure residents received pressure ulcer treatments, interventions, and nutritional supplements as ordered by the physician for 2 of 3 residents reviewed for pressure ulcers. **I. Specific Corrective Actions:** Physicians and families were notified for Residents E and H. Staff assigned were educated on following physician's orders and pressure ulcer treatments. **II. Identification and correction of others:** Four other residents were identified as having pressure ulcers. eTARs were audited for the last 14 days to ensure treatments were completed and physicians' orders followed. **III. Systemic Changes:** All licensed staff were educated on following physician orders and	08/31/2023

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	A Care Plan, dated 1/4/23, indicated a stage 4 pressure ulcer on the sacrum was present. The interventions included treatments would be completed as ordered, supplements were to be given as ordered, and he would be assisted with turning and repositioning. A Physician's Order, dated 1/23/23, indicated to turn resident every two hours. A Physician's Order, dated 5/4/23, indicated the stage 4 pressure ulcer on the sacrum was to be cleansed with normal saline, patted dry, collagen powder (wound healing), then silver alginate (absorbent and antimicrobial wound dressing) was to be applied to the wound bed, then the wound was to be covered by a foam dressing daily. A Physician's Order, dated 5/4/23, indicated an arterial ulcer on the left fifth toe. The treatment was to cleanse the area with normal saline, pat the area dry, Hydrofera Blue (wound protection) was to be applied and then covered with a bordered gauze, three times per week. A Physician's Order, dated 6/27/23, indicated Prostat (protein supplement) 30 cc's (cubic centimeters) was to be given three times a day for the pressure ulcers. A Physician's Order on 5/25/23, indicated the left fifth toe treatment had been changed and now the area was to be cleansed with normal saline, patted dry, and covered with a foam dressing three times a week. The Treatment Administration Record (TAR), dated 5/2023, indicated the treatment to the sacral		pressure ulcer treatments. **IV. <u>Monitoring:</u>** An audit of eTARs to ensure treatments are completed and documented, interventions in place and physician orders followed will be completed by the DON/designee weekly for 4 weeks and monthly for 5 months. May continue another 6 months if ongoing concerns are noted. Results will be reviewed during the monthly QAPI Meetings. [Attachment: Pressure Treatment CQI Audit Tool & QA Tracking Log]	

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	pressure wound had not been completed on 5/16/23. The TAR indicated the treatment for the fifth left toe had not been completed on 5/18/23 and 5/27/23. The TAR, dated 6/2023, indicated the resident had not been turned every two hours as scheduled on 6/1/23 at 6 a.m. and 2 p.m., 6/2/23 at 8 a.m., 6/10/23 at 8 a.m., 6/11/23 at 8 a.m., 6/12/23 at 6 a.m., 6/14/23 at 4 p.m., 6/16/23 at 4 p.m., and 6/30/23 at 8 a.m., 10 a.m., and 12 p.m. The Medication Administration Record (MAR), dated 6/2023, indicated the Prostat had not been given on 6/30/23 at 12 p.m. During an interview on 7/7/23 at 8:13 a.m., the Director of Nursing indicated the treatments, turning/repositioning, and the dietary supplement had not been administered as ordered. 2. Resident H's record was reviewed on 7/11/23 at 9:35 .am. The diagnoses included, but were not limited to, multiple sclerosis A Quarterly MDS assessment, dated 6/28/23, indicated an intact cognitive status, required extensive assistance of two staff for bed mobility, and was dependent on two staff for transfers. There was a stage 4 pressure ulcer present on admission. A pressure relief mattress and cushion for chair was used, nutritional supplements given, and treatments to the area was administered. A Care Plan, dated 3/21/23, indicated pressure ulcers was present. The interventions included treatments were to be completed as ordered.			

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	A Physician's Order, dated 5/28/23 through 6/22/23, indicated the sacral pressure wound was to be cleansed with normal saline, patted dry, packed with collagen rope (wound healing) and covered with a foam dressing daily. The TAR, dated 6/20/23, indicated the treatment had not been completed on June 5, 9, 17, and 20, 2023. A Physician's Order, dated 6/23/23, indicated the sacral pressure wound was to be cleansed with normal saline, patted dry, packed with collagen rope, covered with calcium alginate (stimulated granulation), and then a foam dressing is applied daily. The TAR, dated 6/2023, indicated the treatment had not been completed on 6/27/23. A Physician's Order, dated 3/22/23, indicated Arginaid (dietary supplement to assist in wound healing), one packet was to be given daily. The MAR, dated 6/2023, indicated the Arginaid had not been administered on 6/8/23 and 6/26/23. During an interview on 7/11/23 at 10:32 a.m., the Director of Nursing acknowledged the treatments and dietary supplement had not been administered as ordered. This Federal tag relates to Complaint IN00403128. 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that			

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	resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on record review and interview, the facility failed to ensure urinary catheter care was provided every shift and an antibiotic was administered as ordered for a resident with a urinary tract infection (UTI), for 1 of 2 residents reviewed for urinary catheters. (Resident E)	F 0690	The facility was alleged to be out of compliance by failing to ensure urinary catheter care was provided every shift and an antibiotic was administered as ordered for a resident with a urinary tract infection, for 1 of 3 residents	08/31/2023

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	Finding includes: Resident E's record was reviewed on 7/6/23 at 12:05 p.m. The diagnoses included, but were not limited to, urinary tract infection, Parkinson's disease, and congestive heart failure. A Quarterly Minimum Data Set assessment, dated 6/30/23, indicated a moderately impaired cognitive status, a urinary catheter was present, required extensive assistance with hygiene and was dependent on staff for bathing. A Care Plan, dated 1/9/23, indicated an indwelling urinary catheter was present and there was a potential for infection. The interventions included, peri care was to be provided every shift and as needed. A Care Plan, dated 6/23/23, indicated the indwelling urinary catheter was due to a stage 4 pressure ulcer (full thickness skin loss with extensive destruction, tissue necrosis, or damage to the muscle, bone, or supporting structures) and there was a potential for recurring infections. The interventions included, peri care was to be provided every shift and as needed. A Care Plan, dated 6/23/23, indicated a UTI was present and he was on antibiotics. The interventions included, the antibiotic would be administered as ordered. A Physician's Order, dated 6/24/23, indicated meropenem (antibiotic) 1 gram was to be administered intravenously every eight hours. A Physician's Order, dated 1/4/23 and 6/23/23, indicated urinary catheter care was to be completed every shift.		reviewed for urinary catheters. **Specific Corrective Actions:** Catheter care was provided to Resident E and staff were educated to document care provided to the resident every shift. The physician was notified regarding the antibiotic and staff assigned were educated on medication administration. **II. Identification and correction of others:** Seven residents were identified as having a foley catheter. eTARs were audited to ensure care was provided and documented. No other residents with IV antibiotics were identified. **III. Systemic Changes:** All nursing staff were educated on catheter care and documentation. All licensed staff were educated on medication administration. **IV. Monitoring:** An audit of catheter care and documentation will be conducted by the DON/designee weekly for 4 weeks and monthly for 5 months. May continue another 6 months if ongoing concerns are noted. Results will be reviewed during the monthly QAPI Meetings. [Attachment: Cath Care and Antibiotic for UTI CQI Audit Tool & QA Tracking Log]	

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	155667	A. BUILDING 00 B. WING	07/11/2023

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	The Medication Administration Record (MAR), dated 6/2023, indicated the meropenem had not been administered on 6/25/23 at 2 p.m. and 6/29/23 at 10 p.m. The Treatment Administration Record (TAR), dated 5/2023, indicated the urinary catheter care had not been completed on 5/18/23 and 5/27/23 on night shift. The TAR, dated 6/2023, indicated urinary catheter care had not been completed on 6/1/23 on day shift. During an interview on 7/7/23 at 8:13 a.m., the Director of Nursing indicated the antibiotic and urinary catheter care had not been completed as ordered. This Federal tag relates to Complaint IN00403128. 3.1-41(a)(2)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on record review and interview, the facility failed to care for PICC (peripherally inserted central catheter) line in accordance with professional standards of practice, related to measurement of the catheter to ensure dislodgement had not occurred, flushes, and	F 0694	The facility was alleged to be out of compliance by ensuring care was provided to a PICC line in accordance to professional standards of practice, related to the measurement of the catheter to ensure dislodgement had not	08/31/2023

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	assessments of the insertion site for 1 of 1 residents reviewed with PICC line. (Resident E) Finding includes: Resident E's record was reviewed on 7/6/23 at 12:05 p.m. The diagnoses included, but were not limited to, urinary tract infection, Parkinson's disease, and congestive heart failure. A Care Plan, dated 6/23/23, indicated a PICC line was present in the left upper arm and there was a potential for infection or infiltration. The interventions indicated the status of the PICC line insertion site and integrity of the dressing would be completed every shift and the line would be flushed as ordered. The Physician's Orders, dated 6/23/23 indicated, the PICC insertion site was to be assessed every shift, a flush of 10 milliliters of normal saline was to be completed every shift, and the length of the PICC line was to measured daily. The Medication Administration Record (MAR), dated 6/2023, indicated the PICC insertion site had not been assessed and the line had not been flushed on 6/25/23 day shift. The measurement of the PICC line had not been completed on 6/23/23 and 6/25/23 and on 6/24, 26, 27, 28, 29, and 30/23 there were initials that indicated the PICC had been measured but there was no measurement documented. The MAR, dated 7/2023, indicated the PICC line had not been flushed and assessed on 7/2/23 on the night shift. On 7/7/23 at 8:13 a.m., the Director of Nursing indicated the flushes and assessments had not		occurred, flushes, and assessments of the insertion site for 1 of 1 resident reviewed with a PICC line. **I. Specific Corrective Actions:** Resident E no longer has a PICC line. **II. Identification and correction of others:** An audit was conducted and there are three residents in the facility who currently have a PICC line. Orders were reviewed. All three residents have orders to assess the site, flush per MD order, change dressing weekly, and measure catheter length when discontinued. **III. Systemic Changes:** All licensed nursing staff were educated on PICC line care and professional standards of practice. **IV. Monitoring:** An audit of PICC lines will be conducted by the DON/designee weekly for 4 weeks and monthly for 5 months. May continue another 6 months if ongoing concerns are noted. Results will be reviewed during the monthly QAPI Meetings. [Attachment: PICC CQI Audit Tool & QA Tracking Log]	

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	been completed and there was no measurement documented for the PICC line. Requested a PICC line care policy on 7/7/23 at 8:13 a.m., from the Director of Nursing and received policy for PICC line dressing change on 7/7/23 at 10:59 a.m. This Federal tag relates to Complaint IN00403128. 3.1-47(a)(2)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility	F 0757	The facility was alleged to be out of compliance by failing to ensure	08/31/2023

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	failed to ensure a resident was free from unnecessary medications, related to inadequate monitoring of a blood pressure and pulse, medications administered when pulse and blood pressure out of the prescribed parameters, and medications not given as ordered related to blood pressure medications and insulin for 2 of 4 residents reviewed for unnecessary medications. (Residents E and C) Findings include: 1. Resident E's record was reviewed on 7/6/23 at 12:05 p.m. The diagnoses included, but were not limited to, urinary tract infection, Parkinson's disease, and congestive heart failure. a. A Physician's Order, dated 5/3/23, indicated Entresto 24-26 mg (milligrams) every 12 hours. Hold for blood pressure below 110/50 and/or heart rate less than 60. The Medication Administration Record (MAR), dated 5/2023 indicated: The Entresto was administered at 8 a.m. on 5/3/23 with a blood pressure of 94/48, 5/4/23 with a blood pressure of 100/40, and 5/5/23 with a blood pressure of 100/40, 5/9/23 with a blood pressure of 103/45, 5/20/23 with a blood pressure of 93/54. The Entresto was administered at 8 p.m. on 5/3/23 and 5/4/23 with no blood pressure or pulse taken. On 5/11/23 another Physician's Order for Entresto 24-26 mg to be given every 12 hours and hold for blood pressure less than 110/50 and/or heart rate less than 60 was received. The Entresto was administered at 8 a.m. on 5/26/23 with a blood pressure of 98/55, on 5/28/23 with a		a resident was free from unnecessary medications, related to inadequate monitoring of a blood pressure and pulse, medications administered when pulse and blood pressure were out of the prescribed parameters, and medication not given as ordered related to blood pressure medications and insulin for 2 of 4 residents reviewed for unnecessary medications. **I. Specific Corrective Actions:** Residents E, C were assessed, and physicians and families notified. Staff were educated on medication administration. **II. Identification and correction of others:** Residents were audited for medications with parameters. Mars were audited for the past 14 days to ensure medications were given as ordered. **III. Systemic Changes:** All licensed nursing staff were educated on medication administration. **IV. Monitoring:** An audit of eMARs will be conducted by the DON/designee weekly for 4 weeks and monthly for 5 months. May continue another 6 months if ongoing concerns are noted. Results will be reviewed during the monthly QAPI Meetings. [Attachment: Unnecessary Medication CQI Audit Tool & QA Tracking Log]	

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	blood pressure of 79/42. The Entresto was administered on May 12, 13, 15, 16, 18, 19, 23, and 24, 2023 without the heart rate obtained. The Entresto was administered at 8 p.m. on 5/12/23 with a blood pressure of 105/46, 5/18/23 with a blood pressure of 107/59, and 5/28/23 with a blood pressure of 108/48. It was also administered on May 11, 13, 24, 15, 17, 18, 21, 22, 23, 24, 25, 26, 27, 29, 30, and 31, 2023 without the heart rate obtained. The MAR, dated 6/2023 indicated: The Entresto was administered at 8 a.m. on 6/7/23 with a blood pressure of 102/53. It was also administered on June 6, 9, 11, 12, 13, 14, 15, and 16, 2023 without the heart rate obtained. The Entresto was administered at 8 p.m. on 6/3/23 with a blood pressure of 104/50. It was also administered on June 1, 4, 5, 10, 15, 16, and 17, 2023 without the heart rate obtained. On 6/23/23, another Physician's Order was obtained for Entresto 24-26 mg to be given every 12 hours and hold for blood pressure less than 110/50 and/or heart rate less than 60 was received. The Entresto was administered at 8 p.m. on 6/28/23 with a blood pressure of 105/51. It was administered on June 23 through June 30, 2023 without the heart rate obtained. The MAR, dated 7/2023 indicated: The Entresto was administered at 8 p.m. on July 1, 2, and 4, 2023 without the heart rate obtained. b. A Physician's Order, dated 5/23/23, indicated Midodrine 5 mg three times a day for low blood pressure and was not to be given for blood			

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	pressures over 120/60. The MAR, dated 5/2023, indicated the Midodrine was not given at 4 p.m. on 5/28/23, and was administered at 4 p.m. on 5/29/23 with a blood pressure of 126/60. The MAR, dated 6/2023, indicated the Midodrine was administered at 8 a.m. on 6/7/23 with a blood pressure of 130/64 and on 6/16/23 with a blood pressure of 120/70. The MAR, dated 7/2023, indicated the Midodrine at 4 p.m. was not administered on 7/3/23. During an interview on 7/7/23 at 8:13 a.m., the Director of Nursing indicated the medication had not been given/completed as ordered. 2. Resident C was observed on 7/6/23 at 10:23 a.m., in bed with her eyes closed. The call light was draped over the bedside dresser upper drawer toward the recliner in the room and was out of reach from the bed. Resident C's record was reviewed on 7/7/23 at 10:56 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and diabetes. The Care Plan, dated 10/14/21, indicated a diagnoses of diabetes mellitus. The interventions included accu-checks would be completed as ordered and insulin would be administered as ordered. A Physician's Order, dated 8/11/22, indicated Humalog insulin was to be administered after the accu-check was completed four times a day. The amount of the insulin administered depended on the results of the accu-check (sliding scale).			

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	The Medication Administration Record (MAR), dated 6/2023, indicated the accu-check had not been completed on 6/4/23 before lunch and no insulin had been administered. The accu-check had not been completed on 6/5/23, 6/6/23, 6/10/23, and 6/12/23 before bedtime and no insulin had been administered. A Physician's Order, dated 3/19/23, indicated Lantus insulin, 15 units was to be administered at 5 p.m. The MAR, dated 6/2023, indicated the Lantus insulin had not been administered on 6/6/23 at 5 p.m. During an interview on 7/7/23 at 1 p.m., the Director of Nursing (DON) indicated there were no initials on the MAR that indicated the blood sugars and insulin were administered or completed as ordered. This Federal tag relates to Complaint IN00403128. 3.1-48(a)(3)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and	F 0804	The facility was alleged to be out	08/31/2023

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	interview, the facility failed to serve food that was palatable and attractive and to ensure the correct amount of food was served, for 1 of 2 meals in 1 of 3 Dining Rooms. (Oak Branch Dining Room) Finding includes: The lunch meal in the Oak Branch Dining Room was observed on 7/6/23 at 12:18 p.m. The menu for the meal included Panko chicken parmesan and spaghetti noodles. Dietary Employee 1 was using a small plastic table spoon and placed an unmeasured amount of spaghetti noodles on the residents' plates. The spaghetti was served dry, with no sauce added. The Nursing staff were then serving the meal to the residents in the Dining Room. Dietary Employee 1 indicated at the time of the observation, that the spaghetti sauce had not been delivered and there was not any sauce for the noodles. He indicated the residents could have butter on the noodles if they requested it. 16 meal trays of spaghetti with no sauce was observed being prepared and served. Resident R was interviewed on 7/6/23 at 12:23 p.m. and indicated she preferred spaghetti sauce on the noodles. She indicated the menu was spaghetti noodles and there was no no sauce and she would like sauce. Resident S indicated she wanted sauce on the noodles. Resident T indicated with spaghetti noodles, "you got to have sauce." Resident U also indicated she would have liked sauce for her spaghetti. During an interview with the Dietary Manager on 7/6/23 at 12:30 p.m., she indicated the spaghetti sauce had not been ordered and someone from		of compliance by failing to serve food that was palatable and attractive and to ensure the correct amount of food was served for 1 of 2 meals in 1 of 3 dining rooms. **I. <u>Specific Corrective Actions:</u>** The Dietary Manager was educated to ensure food items needed for the scheduled menu were available prior to the meal prep and meal service. The Dietary Manager was also educated on appropriate measurement of food items to ensure an adequate amount is served. **II. <u>Identification and correction of others:</u>** An audit of the food service items revealed the facility did not have appropriately sized serving utensils for meal service. These items were ordered. **III. <u>Systemic Changes:</u>** Dietary staff were educated on meal service, following menus, and serving sizes. **IV. <u>Monitoring:</u>** An audit will be conducted by the Administrator/designee (Dietary Manager) weekly for 4 weeks and monthly for 5 months. May continue another 6 months if ongoing concerns are noted. Results will be reviewed during the monthly QAPI Meetings. [Attachment: Meal Service Resident Interview CQI Audit Tool & QA Tracking Log]	

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	the kitchen had just left the facility to go an buy some sauce at the store. She indicated the residents were to receive 4 ounces of spaghetti and Dietary Employee 1 should have been aware how much 4 ounces of spaghetti was. The spaghetti sauce was delivered to the Dining Room on 7/6/23 at 12:36 p.m. with only a few meal trays left to be served. During an interview with the Director of Nursing on 7/7/23 at 8:13 a.m., she indicated 33 residents received meals from the facility on the Oak Branch Unit. The dietary spread sheet, dated 4/13/23, and received from the Dietary Manager as current, indicated lunch included Panko chicken parmesan with spaghetti noodles and 4 ounces of spaghetti noodles was to be served with a 4 ounce spoodle. This Federal tag relates to Complaints IN00403128 and IN00406313. 3.1-21(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent			

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	facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview the facility failed to ensure a lunch meal was served in accordance with professional standards for food service safety, related to touching the residents' food with a gloved hand, with no changing of the gloves after touching menu cards, plates, and other items in the serving area, for 1 of 2 meals observed in 1 of 3 Dining Rooms. (lunch meal and Oak Branch Dining Room) Finding includes: The lunch meal in the Oak Branch Dining Room was observed on 7/6/23 at 12:18 p.m. The menu for the meal included spaghetti noodles. Dietary Employee 1 was using a small plastic table spoon to serve the noodles. The spoon was unable to hold the noodles. Dietary Employee 1 would hold the noodles on the spoon with a gloved hand, then placed the noodles on the residents' plates. The gloves were not changed between plates and the Employee was observed touching menu cards, plates, utensils, and other objects in the serving area with the gloved hand. During an interview with the Dietary Manager on 7/6/23 at 12:30 p.m., she indicated the spaghetti should have been serviced with tongs.	F 0812	The facility was alleged to be out of compliance by failing to ensure a lunch meal was served in accordance with professional standards for food service safety, related to touching the residents' food with a gloved hand, with no changing of the gloves after touching menu cards, plates, and other items in the serving area, for 1 of 2 meals observed in 1 of 3 dining rooms. **I. Specific Corrective Actions:** Staff were immediately educated on infection control in the dining room. **II. Identification and correction of others:** Meal service audits were conducted, and no other instances were observed in the dining rooms. **III. Systemic Changes:** All staff were educated on infection control during meal service. **IV. Monitoring:** An audit of following infection control guidelines during meal service will be conducted by the	08/31/2023

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	During an interview with the Director of Nursing on 7/7/23 at 8:13 a.m., she indicated 33 residents received meals from the facility on the Oak Branch Unit. The dietary spread sheet, dated 4/13/23, and received from the Dietary Manager as current, indicated a 4 ounce spoodle was to be used to serve the spaghetti noodles. This Federal tag relates to Complaints IN00403128 and IN00406313. 3.1-21(i)(3)		Administrator/designee (Dietary Manager) weekly for 4 weeks and monthly for 5 months. May continue another 6 months if ongoing concerns are noted. Results will be reviewed during the monthly QAPI Meetings. [Attachment: Meal Service CQI Audit Tool & QA Tracking Log]	
F 0895 SS=D Bldg. 00	483.85(a)-(e) Compliance and Ethics Program 483.85 Compliance and ethics program. §483.85(a) Definitions. For purposes of this section, the following definitions apply: Compliance and ethics program means, with respect to a facility, a program of the operating organization that- §483.85(a)(1) Has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care; and §483.85(a)(2) Includes, at a minimum, the required components specified in paragraph (c) of this section. High-level personnel means individual(s) who have substantial control over the operating organization or who have a substantial role in			

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	the making of policy within the operating organization. Operating organization means the individual(s) or entity that operates a facility. §483.85(b) General rule. Beginning November 28, 2019, the operating organization for each facility must have in operation a compliance and ethics program (as defined in paragraph (a) of this section) that meets the requirements of this section. §483.85(c) Required components for all facilities. The operating organization for each facility must develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, the following components: §483.85(c)(1) Established written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the Act. and promote quality of care, which include, but are not limited to, the designation of an appropriate compliance and ethics program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution; and disciplinary standards that set out the consequences for committing violations for the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles.			

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	§483.85(c)(2) Assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization's compliance and ethics program's standards, policies, and procedures, such as, but not limited to, the chief executive officer (CEO), members of the board of directors, or directors of major divisions in the operating organization. §483.85(c)(3) Sufficient resources and authority to the specific individuals designated in paragraph (c)(2) of this section to reasonably assure compliance with such standards, policies, and procedures. §483.85(c)(4) Due care not to delegate substantial discretionary authority to individuals who the operating organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under the Social Security Act. §483.85(c)(5) The facility takes steps to effectively communicate the standards, policies, and procedures in the operating organization's compliance and ethics program to the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles. Requirements include, but are not limited to, mandatory participation in training as set forth at §483.95(f) or orientation programs, or disseminating information that explains in a practical manner what is required under the program.			

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	§483.85(c)(6) The facility takes reasonable steps to achieve compliance with the program's standards, policies, and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the Act by any of the operating organization's staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within the operating organization without fear of retribution, and having a process for ensuring the integrity of any reported data. §483.85(c)(7) Consistent enforcement of the operating organization's standards, policies, and procedures through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the operating organization's compliance and ethics program. §483.85(c)(8) After a violation is detected, the operating organization must ensure that all reasonable steps identified in its program are taken to respond appropriately to the violation and to prevent further similar violations, including any necessary modification to the operating organization's program to prevent and detect criminal, civil, and administrative violations under the Act.			

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	§483.85(d) Additional required components for operating organizations with five or more facilities. In addition to all of the other requirements in paragraphs (a), (b), (c), and (e) of this section, operating organizations that operate five or more facilities must also include, at a minimum, the following components in their compliance and ethics program: §483.85(d)(1) A mandatory annual training program on the operating organization's compliance and ethics program that meets the requirements set forth in §483.95(f). §483.85(d)(2) A designated compliance officer for whom the operating organization's compliance and ethics program is a major responsibility. This individual must report directly to the operating organization's governing body and not be subordinate to the general counsel, chief financial officer or chief operating officer. §483.85(d)(3) Designated compliance liaisons located at each of the operating organization's facilities. §483.85(e) Annual review. The operating organization for each facility must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations and within the operating organization and its facilities to improve its performance in deterring, reducing, and detecting violations under the Act and in promoting quality of care. Based on record review and interview, the facility	F 0895	The facility was alleged to be out of compliance by failing to ensure	08/31/2023

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	failed to ensure contracted staff were educated on the facility's baseline policies and procedures of the facility, for 6 of 6 Agency Staff reviewed for orientation. (Agency LPN 1, Agency LPN 2, Agency LPN 3, Agency CNA 4, Agency CNA 5, Agency CNA 6) Finding includes: The Agency/Travel Staff Acknowledgement form, dated 6/18/20, and received from the Administrator as current, indicated it was the facility policy to ensure agency staff received the appropriate education to provide care for the residents and to adhere to facility and company policies. Information/policies provided in the acknowledgement packet included, abuse and neglect, elopement, emergency preparedness, HIPPA security, resident rights, restraint free environment and COVID-19 procedures. During an interview on 7/7/23 at 2:07 p.m., the Nursing Staff Scheduler, indicated the Agency/Travel Staff Acknowledgement packet has not been provided for the current Agency staff. The packets have not been completed since April 2023. Review of three Agency LPN's schedule, indicated Agency LPN 1 had worked on July 2, 2023, Agency LPN 2 had worked June 10, 21, 26, 2023 and July 2, 2023, and Agency LPN 3 had worked June 29, 2023 and July 6, 2023 and had not received the facilities information and policy orientation. Review of three Agency CNA's scheduled, indicated Agency CNA 4 had worked June 1, 6, 8,		contracted staff were educated on the facility's baseline policies and procedures of the facility. **I. Specific Corrective Actions:** Agency staff affected who still work for the facility received baseline education. **II. Identification and correction of others:** An audit of current agency staff who work for the facility was conducted and those who had not received baseline education were educated. **III. Systemic Changes:** A new agency education packet, checklist and process was created to ensure all agency staff receive education upon arrival to the facility. All nursing staff were educated on the agency education process. [Attachment: Agency Education Packet] **IV. Monitoring:** An audit will be conducted by DON/Designees (scheduler) weekly for 4 weeks and monthly for 5 months. May continue another 6 months if ongoing concerns are noted. Results will be reviewed during the monthly QAPI Meetings. [Attachment: Agency Education Packet CQI Audit Tool & QA Tracking Log]	

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	12, 13, 14, 15, 16, 19, 20, 21, 22, 28, 29, 30, 2023 and July 2, 2023, Agency CNA 5 had worked June 2, 10, 20, 26, 30, 2023 and July 1,10,13, 2023, and Agency CNA 6 had worked June 8,10, 12, 18, 22, 2023 and July 1, 2, 2023 and had not received the facilities information and policy orientation. This Federal tag relates to Complaint IN00403128.			
R 0000 Bldg. 00	This visit was for the Investigation of Nursing Home and Residential Complaints IN00411197 and IN00412035. This visit included the Investigation of Nursing Home Complaints IN00400228, IN00403128, IN00406313, and IN00408550. This visit included a Residential COVID-19 Quality Assurance Walk Through and a COVID-19 Focused Infection Control Survey. Complaint IN00400228 - No deficiencies related to the allegations are cited. Complaint IN00403128 - Federal/State deficiencies related to the allegations are cited at F686, F690, F694, F757, F804, F812, and F895. Complaint IN00406313 - Federal/State deficiencies related to the allegations are cited at F558, F804, and F812. Complaint IN00408550 - No deficiencies related to the allegations are cited. Complaint IN00411197 - State deficiencies related to the allegations are cited at R0064 and R0090. Complaint IN00412035 - Federal/State deficiencies related to the allegations are cited at F684.	R 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Oak Grove Christian Retirement Village desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on, August 3, 2023. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.	

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	Survey dates: July 6, 7, 10, and 11, 2023 Facility number: 010823 Residential Census: 34 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/17/23.			
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on record review and interview, the facility failed to protect residents' property and financial information from theft related to misappropriation by staff and the Administrator failed to conduct thorough investigations per policy to help prevent continued misappropriation for 6 of 6 residents reviewed for misappropriation. (Residents BB, CC, DD, EE, FF, JJ and Staff 1) Findings include: During a review on 7/7/23 at 11:20 a.m. of 4 facility IDOH reported incidents involving misappropriation, the facility Administrator/ VP of Operations (VPO) provided separate investigation folders for the 4 incidents plus a police report related to the incidents.	R 0064	R064 It is the policy of this facility to ensure that residents' property and financial information is protected from theft. The community was alleged to be out of compliance by failing to conduct a thorough investigation per policy related to misappropriation. **I. <u>Specific Corrective Actions:</u>** The Administrator and management team were educated regarding investigation of misappropriation. The policy was reviewed in detail. **II. <u>Identification and correction of others:</u>** Letters were sent to residents and or family members about the misappropriation and to check	08/03/2023

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	Review of the police report indicated the first reported misappropriation incident involving Resident BB was reported to them by her son on 5/24/23 for fraudulent credit card charges occurring on 5/4/23, both online in other states and at a store in a nearby town, which was then investigated by their local police in conjunction. Next, a narrative report section, dated 6/14/23 at 9:35 p.m., addressed a report of theft at the facility for Resident FF from her locked lockbox, for which the key was found on her floor. On 6/17/23 at 10:40 a.m., the facility VP of Operations (VPO) called the local Police Department to report another theft and unauthorized use of a credit card for Resident CC. The officer went to the victim's apartment and spoke to her. She had kept her Discover card in her billfold in her purse, which was hung up with her clothes in her closet. She was frequently out of her room participating in activities and would leave the door unlocked. The officer also spoke with her son via phone. He had spoken with the credit card company and reported numerous charges on the card in the past few days, including one at the local Dollar Store and another at a local grocery store and said a statement would be sent. Other fraud/ theft cases of note included [Resident BB] credit card online purchases, $140 cash from [Resident FF] on 6/14/23, as well as $20 from [Resident EE] and electronic theft from [Resident JJ] between 5/22-5/25/23 (incidents for Residents EE and JJ not yet reported to police). Video was viewed from the local Dollar General which showed a clear view of the suspect scanning at the self checkout. The photo was then taken to the facility and was identified as [Staff 1] who worked as a shower tech. Contact was made with the suspect, who initially denied the allegations, then admitted to Dollar General purchase and stealing [Resident CC's] card from the floor of her closet at the		their valuables and credit card statements. **III. <u>Systemic Changes:</u>** The Administrator and management team were educated regarding investigation of abuse/misappropriation. [Attachment: Abuse P&P] **IV. <u>Monitoring:</u>** An audit will be completed by Administrator/designee weekly for 4 weeks, then monthly for 5 months. May continue another 6 months if ongoing concerns are noted. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: Reportable/Investigation CQI & QA Tracking Log]	

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	facility, as well as the local grocery purchase. She initially denied the store purchase with Resident BB's card, then admitted after she was made aware of video evidence matching her vehicle. She said she was aware of the other reports of the theft of money and jewelry, but denied involvement. 1) Resident BB's record was reviewed on 7/10/23 at 10:00 a.m. The resident was admitted on 1/25/22. There was no investigation folder for Resident BB provided other than the police report. There was no documentation in the resident's electronic chart regarding the misappropriation incident or any follow up. During an interview on 7/7/23 at 12:15 p.m., the VPO indicated she was made aware of the misappropriation for Resident BB by the Police Department Detective on 6/16/23 when she was reporting a separate stolen credit card incident to them. It was never reported to her by the resident's family. She did not do a separate investigation or follow up with the resident, she just went with what the police had done. She did not interview any other residents or staff. 2) Resident CC's record was reviewed on 7/7/23 at 1:30 p.m.. An IDOH reportable, dated 6/16/23 at 11:32 p.m. with follow up dated 6/19/23 at 8:47 am., indicated, "Identified date & time of incident 6/16/23 10:01 am. Description: 6/16/23 The resident's granddaughter called and said there was fraudulent activity on the resident's credit card. This happened a few weeks ago and now she has a new card and there is activity at a local store and the resident hasn't been out of the building today. Action Taken added -- 6/16/2023 The local police			

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	were called and told of the situation. An investigation was started. Type of preventative measures added -- 6/16/2023: Offered the resident a lock box to keep her wallet in and suggested she start locking her apartment door. Follow up added -- 6/19/2023 There was a video of an employee using this resident's credit card at a local store. Two other staff members positively ID'd the employee in the video. The police officer interviewed her and she confessed to taking this resident's credit card and another incident that happened a month or so ago. The employee who confessed was [Staff 1], she was notified per phone that her employment with Oak Grove was terminated effective immediately. She acknowledged the message via text at 7:59 p.m. Friday, June 16, 2023. She will be sent a letter from Oak Grove officially terminating her employment. The facility investigation folder included the police report, a picture of the suspected employee from the store video with notes of "Per Officer [name], Yes took discover plus Lowell incident," two signed and undated statements from housekeepers indicating the resident's room was cleaned by both of them on Tuesday, June 13th and no debit/credit card was seen with nothing out of the ordinary in the room, and copies of staff as worked for all shifts 6/9 - 6/16/23 as well as a shower aide weekly 4:30-9:30 a.m. printed on 4/14/23. There was also a hand-written sheet which indicated "6/16/23 10a granddaughter, notes: "May 30th 3 weeks ago cc [credit card] missing & fraudulent charges, $50 cash, Thurs 6/8 new card now missing & charges at $ General $130.78, [check mark] on shift 15th, 16th 8-13". There were no other interviews with staff or residents or any other signed statements in the investigation.			

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	There was no documentation in the resident charting related to the misappropriation issue or any follow up. During an interview with Resident CC on 7/10/23 at 1:30 p.m., she indicated around June 16, her granddaughter called her and told her a charge came up on her credit card for dollar general and asked if she was there. She went and checked for her card in her purse, and her discover card was missing, as well as a $50 bill missing from a drawer in a gift card box. She reported to staff who called the police and the facility VPO was notified. Both came to interview her and she was on the phone with her step son also. She has had no other follow up from facility staff. She told her friends in the facility this had happened so they could be aware. She has since heard of several others with charges or things missing, but was not aware of any other residents prior to her issue. 3) Resident DD's record was reviewed on 7/10/23 at 8:50 a.m. The resident was admitted on 5/4/18. An IDOH reportable incident including follow up, dated 6/19/23, indicated: "Description added -- 6/19/2023 The resident reported to the aide that after hearing talk regarding what happened to another resident decided to check her purse. Resident discovered she was missing $40.00 from her purse. She was given $60.00 approximately 2 or so weeks ago. Spent one of the $20s on ice cream. Still had 2 $20 dollar bills and some singles. When she checked her purse the 2 $20s were gone. Since the time line is consistent with recent incidents it is more than likely the same person. Action Taken added -- 6/19/2023 Social Service spoke with the resident. Offered her a lock box to keep any money or			

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	valuables inside. Type of preventative measures added -- 6/19/2023 Encouraged resident to use a lock box and keep the key and apartment key with her and to keep her apartment locked when she was not there. Follow up added -- 6/19/2023 Will monitor the situation but it is most likely the person who confessed to taking the credit cards also took the money from this resident's purse." The investigation folder for Resident CC only contained a single printed email dated 6/19/23 at 8:09 a.m. from a CNA reporting the following concern to be considered with the other "group" incident thefts: [Resident CC] indicated last night (around 8p) that she is also a victim resulting in loss of approximately $40. [Resident BB] sits at her dinner table. After all the talk they were having about what happened to [Resident BB], [Resident CC] decided to check her purse late last night. [Resident CC] has discovered that she is missing $40 from her purse... Approx 2 weeks or so ago her son [name] gave her $60 (three $20s). She spent one of the $20s on ice cream for the grandkids, her change was approx $3. When Resident CC checked her purse late last night, she discovered that these singles were still in her purse, but the 2 remaining $20 bills were gone..." There were no other papers in the investigation, including no involved resident interview, other resident or staff interviews, or documentation of notification of family or local police. There was no documentation in the resident's charting related to the misappropriation or any follow up. 4) Resident EE's record was reviewed on 7/10/23 at 9:10 am. She was admitted on 4/7/18.			

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	An IDOH reportable incident, dated 6/16/23 with follow up on 6/19/23, indicated: "Description added -- 6/16/2023 The resident reported to her daughter that $20.00 was stolen. Action Taken added -- 6/16/2023 A police officer was here concerning another incident and so took this information also. Type of preventative measures added -- 6/16/2023 A lock box was provided to the resident to keep any cash or other valuables in for safety. Follow up added -- 6/19/2023 The resident was provided a lock box and was encouraged to keep her lock box key and apartment key with her and to keep her apartment locked when she was not there. Another incident resulted in an employee being fired who stole and confessed to stealing a credit card. It is likely this same person took the $20.00." The investigation folder contained a resident face sheet and a "Concern Form", dated 6/16/23. for the resident which indicated the front desk was contacted by a family member with a concern of $20 missing/ stolen. The remainder of the form was blank with no follow up and no signatures. There was nothing further in the investigation, including any interview with the involved resident or any other residents or staff. There was nothing to indicate details on when or where she had the $20 or when it was last seen or found missing. There was no documentation in resident charting related to the misappropriation or any follow up. 5) Resident FF's record was reviewed on 7/7/23 at 2:25 p.m. She was admitted on 3/15/22. An IDOH reported incident, dated 6/15/23 with follow up on 6/19/23, indicated: "Description			

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	added -- 6/15/2023 The resident reported money missing from her black purse and her lock box to the aide on duty last night 6/14/23. On Tuesday, 6/13/23 before lunch everything was there. When SS spoke to her this morning she is also missing 2 gold chains. Action Taken added -- 6/15/2023 The local police were called and came to take a statement from the resident last evening after the stolen money was reported to the aide. The aide wrote a statement of what the resident reported happened. Type of preventative measures added -- 6/15/2023 The resident is now going to keep her apartment door locked. Previously it was unlocked when she left to go to activities and meals. The resident will be encouraged to keep her money in the bank and request it from the business office when she needs spending money. Follow up added -- 6/19/2023 We took statements from staff who worked upstairs in Assisted Living no one saw anything and no one admitted taking the money or jewelry. However, in a separate incident, an employee who worked upstairs and had access admitted to taking another resident's credit card. This resident will keep her valuables in the lock box and will keep the key on her wrist along with her apartment key. Her apartment will now be locked when she is not there." The investigation folder included the following: - Police report with case number available. - A signed statement from a CNA dated 6/14/23 at 8:40 p.m. which indicated Resident FF reported $200 has been stolen from her room. One envelope had $40 in it and it was in a small black purse. One envelope had $160 in it. The purse was in her underwear drawer. The key to her lock box was also in the underwear drawer. The $160 was in the lock box. The resident stated that she saw her lock box key on the floor next to her bed. This is when she discovered that the money was missing.			

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	There was then a list of when she was out of the room that day. She had company after an activity and before lunch. She was with the company the entire time. The last time she saw the money was over the weekend. She gets her hair done every Friday & pays for it with cash. An investigation statement from the SSM: apx 9:48 am, Res stated lock box key was find [sic] by bed last night. Res stated she checked her lock box & missing was her money. Res reported today 2 gold chain necklaces were missing. Res reported she looked over the weekend & the money was there, she looked on Tues before lunch & everything was there. Everything came up missing last night. - Staffing schedule as worked included for 6/13 and 6/14/23 with AL staff highlighted & check marked for statements. - Written or printed emailed statements for a housekeeper, 2 LPNs, 2 CNAs, 1 trainee & 1 other unidentified staff. There were no written statements or documented interviews from any other residents. There was no documentation in the resident's charting related to the misappropriation or any follow up. Interview with Resident FF on 7/10/23 on 10:38 a.m. indicated about 2 weeks ago she had gone to get her nails done, then a friend came to visit, saw 2 aides in her room picking up trash while she was out (she found this out later). That night when she went to get in bed, she saw something shiny on the floor and it was the key to her lockbox. She checked it right away and found money was gone from lockbox and her purse and she was also missing 2 necklaces from the box where the lockbox key was kept. She told the CNA right			

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	away, who reported it. The next day the nurse and SS came and looked through the apartment and talked to her, but did not find the missing items. Police came and took a report and the facility has reimbursed the money. During an interview with AL (Assisted Living) Social Service regarding the above allegations, on 7/10/23 at 10:50 a.m., she indicated the only resident follow up she had completed was for Resident FF. She and a nurse talked to her the following day and also looked for her missing money. She had talked to several other residents just on that same hall and filled out a form and gave them to the VPO, but was unsure why they were not in the investigation folders. The VPO directed follow up for any investigation and would indicate which residents to interview, so she had not talked to any of the other residents residing in AL as part of any investigation, even after additional allegations arose. The facility had recently conducted its annual random resident surveys and a concern had flagged for Resident CC regarding feeling safe and secure in the facility, so she completed a follow up with her on 6/28/23 and the resident indicated her concern was related to missing money. The VPO was listed as the resolver on 6/30/23. Interview with the VPO on 7/10/23, related to the timeline and misappropriation investigations, indicated she first knew of the misappropriation issue on 6/5/23 regarding Resident JJ and a debit card issue. She spoke with the daughter, who reported charges from 5/22-5/25/23 for which the bank had told her "this has happened more than once at [facility name]". The VPO then called the bank, who said they could find no pattern linked to the facility currently and thought it was of electronic origin possibly related to social media,			

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	but they would continue to monitor. She indicated she just went with what the bank had indicated and did not report to IDOH or the police department and did not complete any investigation. The next known incident was for Resident FF. It was reported to IDOH on 6/14 and the police were called and a report was taken. On 6/16/23, she called the police for Resident CC and when they came here to take a statement, they made her aware of Resident BB's reported incident. Resident EE's daughter was here at that time and had just told staff of her missing money, so police were made aware. The facility did not have any resident meetings and staff did not interview any other alert residents to see if anyone else was missing anything. She did not interview staff for the other residents to see if anything was noticed. There was no thorough investigation to substantiate that nothing else has gone missing since the employee suspected was terminated or rule out any other possible explanations or potential suspects, she just went with the police investigation and bank employee statements and assumed all of the incidents were related. A policy titled. "Abuse, Neglect, Exploitation Policy" was received on 7/6/23 at 11:09 a.m. by the VPO as current. The policy indicated the following: "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property ... defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent ...			

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	III. Prevention ... H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors... V. Investigation of Alleged Abuse, Neglect and Exploitation. A. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation ... 3. Investigating different types of allegations 4. Identifying and interviewing all involved persons. including the alleged victim, perpetrator, witnesses, and others who might have knowledge of the allegations ... 6. Provide complete and thorough documentation of the investigation ... VII. Reporting/ Response. A...1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified time frames. ... b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury...5. Taking all necessary actions as a result of the investigation, which may include, but are not limited to: a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences...." This state residential finding relates to Complaint IN00411197.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall			

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	include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.			

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	(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure all allegations of misappropriation were reported to the Indiana Department of Health (IDOH) for 2 of 6 residents reviewed for misappropriation. (Residents BB and JJ) Findings include: Cross reference R0064. 1) During a review on 7/7/23 at 11:20 a.m. of 4 facility IDOH reported incidents involving misappropriation, the facility Administrator/ VP of Operations (VPO) provided separate investigation folders for the 4 incidents plus a police report related to the incidents. Resident BB did not have an investigation folder. Review of the police report indicated the first reported misappropriation incident involving Resident BB was reported to them by her son on 5/24/23 for fraudulent credit card charges occurring on 5/4/23. During an interview on 7/7/23 at 12:15 p.m., the VPO indicated she was made aware of the misappropriation for Resident BB by the Police Department Detective on 6/16/23 when she was reporting a separate stolen credit card incident to them. It was never reported to her by the resident's family. She did not report the incident for Resident BB to IDOH when she was made aware because "it happened a few weeks before."	R 0090	R090 It is the policy of this facility to ensure that all allegations of misappropriation are reported to the Indiana Department of Health. **I. Specific Corrective Actions:** The Administrator reported the other 2 allegations immediately. **II. Identification and correction of others:** Letters were sent to residents and or family members about the misappropriation and to check their valuables and credit card statements. **III. Systemic Changes:** The Administrator and management team were educated regarding investigation of abuse/misappropriation. [Attachment: Abuse P&P] **IV. Monitoring:** An audit will be completed by Administrator/designee weekly for 4 weeks, then monthly for at 5 months. May continue another 6 months if ongoing concerns are noted. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: Reportable/Investigation CQI & QA Tracking Log]	08/03/2023

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	2) During a review on 7/7/23 at 11:20 a.m. of 4 facility IDOH reported incidents involving misappropriation, the facility Administrator/ VP of Operations (VPO) provided separate investigation folders for the 4 incidents plus a police report related to the incidents. Resident JJ did not have an investigation folder. Review of the police report indicated Resident JJ was one of the involved residents listed with electronic theft between 5/22-5/25/23, which had not yet been reported directly to the police department. Interview with the VPO on 7/10/23 at 9:20 a.m., indicated she was not aware of Resident JJ when asked and said she did not see the name on the corporate email thread or the police report and did not remember any issue. She would need to call police detective or ask staff. Interview with the VPO on 7/10/23 at 11:30 a.m. regarding the timeline of events, indicated she found her other notes and the first she knew of any misappropriation issue was on 6/5/23 regarding Resident JJ and a debit card issue. She spoke with the daughter, who reported charges from 5/22-5/25/23 for which the bank had told her "this has happened more than once at [facility name]". The VPO then called the bank, who said they could find no pattern linked to the facility currently and thought it was of electronic origin possibly related to social media, but they would continue to monitor. She indicated she just went with what the bank had indicated and did not report to IDOH or the police department and did not complete any investigation. A facility abuse policy, received from the Administrator as current, indicated the purpose			

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	was for the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property, which was defined as the deliberate misplacement, exploitation, or wrongful use of a resident's belongings or money without the resident's consent. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) should be within specified time frames, not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. This state residential finding relates to Complaint IN00411197.			