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	10/22/2024

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 a Recertification and State Licensure Survey and the Investigation of Complaint IN00442131. This visit included a State Residential Licensure Survey. Complaint IN00442131 - Federal/State deficiencies related to the allegations are cited at F695. Survey dates: October 15, 16, 17, 18, 21, and 22, 2024 Facility number: 010823 Provider number: 155667 AIM number: 200236630 Census Bed Type: SNF/NF: 44 SNF: 8 Residential: 29 Total: 81 Census Payor Type: Medicare: 8 Medicaid: 26 Other: 18 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/29/24.	F 0000	This Plan of Correction shall serve as this facility's credible allegation of compliance. Completion and implementation of this plan is not a confirmation of the statements and facts set out in this survey, but rather an effort to continually improve services to our residents. Please consider allowing submission of education and audits as proof of compliance. Respectfully Submitted Beth Ingram VP of Operations Oak Grove Christian Retirment Village	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to ensure a resident and/or their	F 0623	Step One: The required notice was resent to the resident and family	11/22/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Beth Ingram	Administrator	11/11/2024

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	Responsible Party were notified in writing related to a transfer to the hospital for 1 of 2 residents reviewed for hospitalization. (Resident 15) Finding includes: Resident 15's record was reviewed on 10/17/24 at 9:50 a.m. Diagnoses included, but were not limited to, heart failure, diabetes mellitus and fluid overload. The Quarterly Minimum Data Set assessment, dated 7/27/24, indicated the resident was significantly impaired for daily decision making. Progress Notes indicated the resident was sent to the hospital on 8/24/24 and returned to the facility on 8/29/24. There was no documentation to indicate the State approved transfer form was completed and sent with the resident. There was no documentation to indicate the resident's Responsible Party had received written notification of the resident's transfer to the hospital. During an interview on 10/17/24 at 9:20 a.m., RN 4 indicated when residents were sent out to the hospital they were sent with a face sheet, a copy of the DNR, bed hold policy and transfer/ discharge papers. Copies were made and given to medical records. During an interview on 10/17/24 at 2:20 p.m., the Director of Nursing indicated they were unable to locate the State approved transfer form. 3.1-12(a)(6)(A)(ii)		and a copy retained for our records. Step Two: The discharge notifications of recent transfers and discharges was reviewed, and any missing transfer notifications were resent with a copy retained. Step Three: Nursing Staff were re-educated to the importance of retaining proof that the notice of transfer and discharge was given prior to transfer to the hospital. Step Four: The Social Services Director or her Designee will audit the medical record to verify that a notice of transfer or discharge has been retained once weekly for the first four weeks, then once every two weeks for the next 4 weeks, then monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	

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F 0625 SS=D Bldg. 00	3.1-12(a)(6)(A)(iii) 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were sent the facility's bed hold and reserve bed payment policy before and upon transfer to the hospital for 1 of 2 residents reviewed for hospitalization. (Resident 15) Finding includes: Resident 15's record was reviewed on 10/17/24 at 9:50 a.m. Diagnoses included, but were not limited to, heart failure, diabetes mellitus and fluid overload. The Quarterly Minimum Data Set assessment, dated 7/27/24, indicated the resident was significantly impaired for daily decision making. Progress Notes indicated the resident was sent to the hospital on 8/24/24 and returned to the facility on 8/29/24. There was no documentation to indicate the facility's bed hold policy was completed and sent with the resident. There was no documentation to indicate the resident's Responsible Party had received written notification of the facility's bed hold policy. During an interview on 10/17/24 at 9:20 a.m., RN 4 indicated when residents were sent out to the hospital they were sent with a face sheet, a copy of the DNR, bed hold policy and transfer/ discharge papers. Copies were made and given to	F 0625	Step One: The bed hold policy was sent to the resident identified and a copy retained for record. Step Two: the records of residents recently transferred or discharged were reviewed and notice was issues if not found in the record. Step Three: Nursing staff were re-educated to the importance of retaining a copy of the bed hold policy prior to transferring to the hospital. Step Four: The Social Services Director or her designee will audit that a copy of the bed hold policy was retained prior to transfer to the hospital once weekly for the first four weeks, then once every two weeks for the next 4 weeks, then monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	11/22/2024

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	medical records. During an interview on 10/17/24 at 2:20 p.m., the Director of Nursing indicated they were unable to locate the bed hold policy. 3.1-12(a)(12)(A)			
F 0640 SS=A Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments Based on record review and interview, the facility failed to successfully complete and export the Minimum Data Set (MDS) assessment in a timely manner for 1 of 22 residents whose MDS assessments were reviewed. (Resident 27) Finding includes: The record for Resident 27 was reviewed on 10/18/24 at 2:33 p.m. Diagnoses included, but were not limited to, pneumonia and type 2 diabetes mellitus. The resident admitted to the facility on 9/5/24 and was discharged on 9/27/24. The Discharge - Return Not Anticipated MDS assessment, dated 9/27/24, indicated it was not completed or submitted as of the review date. During an interview on 10/22/24 at 2:14 p.m., the Administrator indicated she had no further information to provide. The facility was going thru a transition with MDS Coordinators and it was missed. A Policy titled, "MDS 3.0 Completion," indicated "...Policy Implementation...2. Types of OBRA Assessments...f. Discharge Assessment - completed using the discharge date as the ARD. Must be completed within 14 days of the	F 0640	No Plan of Correction is required for a level A citation.	10/22/2024

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	discharge data/ARD." 483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to section GG functional assessment completion and intravenous (IV) medication use for 3 of 22 MDS assessments reviewed. (Residents 36, D and 211) Findings include: 1. Resident 36's record was reviewed on 10/16/24 at 2:27 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, depression and unspecified dementia. The Annual MDS assessment, dated 9/4/24, indicated the resident was cognitively intact. Section GG, which indicated the functional level of the resident, was not completed. During an interview on 10/17/24 at 10:58 a.m., the Director of Nursing indicated section GG had not been completed. There was no additional information provided. 2. Resident D was observed in bed on 10/15/24 at 9:44 a.m. Snacks and drinks were observed at her bedside. There were no IV supplies or equipment in her room. The resident indicated she ate a regular diet and had not received any IV nutrition. Resident D's record was reviewed on 10/17/24 at 1:44 p.m. Diagnoses included, but were not limited to, malignant neoplasm of kidney, urinary tract infection, pathological fracture, bone cancer, paraplegia, and neuromuscular dysfunction of			
F 0641 SS=A Bldg. 00		F 0641	No Plan of Correction is required for a level A citation.	10/22/2024

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	bladder. The Quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated the resident was cognitively intact, and that the resident was received parenteral (IV) nutrition. During an interview on 10/22/24 at 2:55 p.m., the Director of Nursing indicated the resident had not received parenteral nutrition, and the MDS was coded in error. 3. Resident 211's record was reviewed on 10/18/24 at 9:16 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, Alzheimer's disease, and absence of the right leg above the knee. The Quarterly Minimum Data Set (MDS) assessment, dated 9/9/24, indicated the resident was cognitively intact for daily decision making. Section GG - Activities of Daily Living (ADL) capabilities was not completed. During an interview on 10/22/24 at 2:14 p.m., the Administrator indicated she had no further information to provide.			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on observation, record review, and interview, the facility failed to ensure care plans were reviewed and revised to include changes related to IV (intravenous) fluids for 1 of 22 resident care plans reviewed. (Resident D) Finding includes: Resident D was observed in bed on 10/15/24 at 9:44 a.m. There were no IV supplies or equipment	F 0657	Step One: The plan of care for the resident identified was updated Step Two: The care plans of all residents were audited to assure accuracy and updated as needed. Step Three: Nursing staff were re-educated on the importance of amending the plan of care as care	11/22/2024

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	in her room. The resident indicated she had not had an IV since returning to the facility from the hospital on 9/14/24. Resident D's record was reviewed on 10/17/24 at 1:44 p.m. Diagnoses included, but were not limited to, malignant neoplasm of kidney, urinary tract infection, pathological fracture, bone cancer, paraplegia, and neuromuscular dysfunction of the bladder. The Quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated the resident was cognitively intact. A Care Plan, dated 9/14/24, indicated the resident needed IV fluids for dehydration. Interventions included, but were not limited to, administer IV fluids, monitor IV site and arm every shift, and complete flushes per orders. There were no Physician's Orders for IV fluids. During an interview on 10/22/24 at 2:55 p.m., the Director of Nursing (DON) indicated the resident was not receiving IV fluids, and the care plan would need to be modified. 3.1-35(c)(1)		needs change. Step Four: The Director of Nursing or her designee will audit care plans related to an IV once weekly for the first four weeks, then once every two weeks for the next 4 weeks, then monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to ensure parameters were in place for Physician notification related to weight monitoring for a resident with three times a week weights for 1 of 1 resident reviewed for edema. (Resident 15)	F 0684	Step One: The physician order was updated for the resident identified. Step Two: All other orders for weight monitoring were audited for accuracy and updated if needed.	11/22/2024

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	Finding includes: Resident 15's record was reviewed on 10/17/24 at 9:50 a.m. Diagnoses included, but were not limited to, heart failure, diabetes mellitus and fluid overload. The Quarterly Minimum Data Set assessment, dated 7/27/24, indicated the resident was significantly impaired for daily decision making. A Physician's Order, dated 4/22/24, indicated to weigh the resident every Monday, Wednesday and Friday related to congestive heart failure. There were no parameters in place for when to notify the Physician of a change in weight. The current Fluid Maintenance Care Plan indicated the resident was at risk for fluid volume overload due to congestive heart failure. Interventions included, but were not limited to, monitor electrolytes, assess for presence of edema, follow fluid volume restriction orders and monitor input and output. During an interview on 10/18/24 at 10:50 a.m., the Director of Nursing indicated she had contacted the Nurse Practitioner and received orders to notify him if there was a five pound increase in a week. She indicated it had not been on the previous order. The "Weight Monitoring Policy", revised on 9/4/24, indicated, "...The care plan should address the following, to the extent possible:...d. Time frame and parameters for monitoring...." 3.1-37		Step Three: All nursing staff were re-educated on the importance of including parameters when obtaining an order to monitor weight. Step Four: The Director of Nursing or her designee will audit physician's orders for weight monitoring to assure parameters are in place once weekly for the first four weeks, then once every two weeks for the next 4 weeks, then monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	

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F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the treatment and services necessary to promote healing related to updating and following Physician's Orders for wound care for 1 of 3 residents reviewed for pressure ulcers (Resident 20). Finding includes: During an observation of Resident 20's wound care on 10/21/24 at 10:54 a.m., the Wound Care Nurse was observed changing the dressings on the right heel, right ankle, and right lower leg. She entered the room, washed her hands with soap and water, and donned a gown and gloves. She removed the old dressings from the right lower leg, right ankle, and right heel, each dated 10/19/24. She removed her gloves and donned new gloves, without performing hand hygiene between glove use. She sprayed wound cleanser to gauze and cleaned the right lower leg and then threw away the gauze. She removed more gauze, sprayed it with wound cleanser and cleaned the right ankle. She removed more gauze, sprayed it with wound cleanser and cleaned the right heel. She opened a foam dressing, reached into her pocket and removed a marker, wrote the date on the foam dressing, and continued to perform wound care. She applied honey wound gel to the foam dressing and placed it over the right heel wound. She continued to apply the dressings to the right ankle and right lower leg by putting drops of Tetracyte (topical antibiotic) to the open areas, an oil emulsion dressing, and then a calcium alginate dressing over the top with rolled gauze to hold the dressing in place. She dated the dressing,	F 0686	Step One: The treatment plan for the resident identified was updated to match the new orders. Step Two: All other wound orders were audited to verify that treatment plans match physician orders. Step Three: Nursing Staff were re-educated on the importance of updating treatment plans as physician's orders and amended. Step Four: The Director of Nursing or her designee will audit wound orders once weekly for the first four weeks, then once every two weeks for the next 4 weeks, then monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	11/22/2024

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	removed her gloves, and washed her hands. Resident 20's record was reviewed on 10/17/24 at 11:47 a.m. Diagnoses included, but were not limited to, cellulitis to the right lower limb, acute kidney failure, and heart failure. The Significant Change in Status Minimum Data Set (MDS) assessment, dated 8/23/24, indicated the resident was significantly impaired for daily decision making. He required assistance from staff for transfers and bed mobility. A Physician's Order, dated 9/26/24, indicated apply medical grade honey gel to right heel and cover with border gauze on Tuesday, Thursday, and Saturday. A Wound Care Progress Report, dated 10/10/24, indicated the resident had an unstageable right lateral heel pressure ulceration measuring 4.5 centimeters (cm) by 3.5 cm by 0.1 cm. Treatment orders included to apply Tetracyte to the wound bed, followed by medical grade honey and calcium alginate. Cover the wound with bordered gauze daily and as needed for soiled or loose dressing. During an interview on 10/21/24 at 11:26 a.m., the Wound Care Nurse indicated the wound care was ordered for three times a week. She was unaware of daily treatment changes. During an interview on 10/22/24 at 2:14 p.m., the Administrator indicated she had no further information to provide. A policy titled, "Wound Treatment Policy," indicated "...1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and			

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	frequency of dressing change." 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure an indwelling Foley (urinary) catheter collection bag for a resident with a history of infection was covered and not hanging off the top of a garbage can for 1 of 1 residents reviewed for urinary catheters. (Resident C) Finding includes: On 10/16/24 at 10:37 a.m., Resident C was observed sitting in a recliner in her room. The resident's urinary catheter bag was uncovered and hanging off the top of a garbage can sitting next to her. The uncovered bag was touching the top and the side of the garbage can. The garbage can was observed with trash in the can. On 10/16/24 at 3:15 p.m., the Assistant Director of Nursing (ADON) was asked to observe the resident's catheter bag. Resident C was observed sitting in a recliner in her room. The resident's urinary catheter bag was uncovered and hanging off the top of a garbage can sitting next to her. The uncovered bag was touching the top and the side of the garbage can. The garbage can was observed with trash in the can. Record review for Resident C was completed on 10/16/24 at 3:10 p.m. Diagnoses included, but were not limited to, cancer, hypertension, depression, and COPD (chronic obstructive pulmonary disease).	F 0690	Step One: A cover was obtained, and the bag was relocated for the resident identified. Step Two: The catheters for all other residents were observed and addressed as needed. Step Three: Nurses and CNAs will be re-educated on the importance of covering the catheter bad as well as placement of the bag. Step Four: The Director of Nursing or her designee will audit resident's catheters three times weekly for the first four weeks, then once every week for the next 4 weeks, then monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	11/22/2024

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	The Annual Minimum Data Set (MDS) assessment, dated 8/23/24, indicated the resident was moderately cognitively impaired. The resident required a substantial maximal assistance with toileting, hygiene, and transfers. The resident had an indwelling urinary catheter. A Care Plan, dated 12/1/23, indicated the resident had an indwelling urinary catheter with potential for infection. An intervention included for catheter care as ordered. The October 2024 Physician's Order Summary indicated the resident had the following orders: - catheter care every shift - ensure catheter bag was below the waist, covered, and the tubing was not touching the floor A Physician's Order, dated 8/20/24 and discontinued 8/27/24, indicated Cipro (antibiotic) 250 mg (milligrams) twice a day for 7 days for a urinary tract infection. During an interview on 10/16/24 at 3:15 p.m., the ADON indicated the resident's catheter bag should not have been attached to the garbage can. 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review and interview, the facility failed to ensure residents received the necessary care and treatment related to respiratory equipment not changed as ordered and incorrect flow rate of oxygen (O2)	F 0695	Step One: The oxygen issues identified in the survey were addressed immediately. Step Two: Oxygen use was	11/22/2024

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	administered for 3 of 4 residents reviewed for respiratory care. (Residents B, C, and D) Findings include: 1. On 10/15/24 at 10:16 a.m., Resident B was observed sitting in a wheelchair in her room. An oxygen concentrator was next to the resident. The water humidification bottle on the concentrator was dated, 10/6/24. The resident's night stand drawer was open and a nebulizer treatment mask was observed, dated 10/6/24. Record review for Resident B was completed on 10/16/24 at 3:02 p.m. Diagnoses included, but were not limited to, heart failure, respiratory failure, and COPD (chronic obstructive pulmonary disease). The Quarterly Minimum Data Set (MDS) assessment, dated 8/19/24, indicated the resident was moderately cognitively impaired. The resident required oxygen therapy. A Care Plan, dated 11/19/23, indicated the resident had a diagnosis of COPD and was dependent on supplemental oxygen. An intervention included to administer oxygen. The October 2024 Physician's Order Summary (POS), indicated the following orders: - DuoNeb (medication used to treat airway narrowing) 3 ml (milliliters), inhale 1 vial four times daily with nebulizer machine - Change respiratory equipment: O2 tubing, humidifier, nebulizer tubing every week. During an interview on 10/15/24 at 10:59 a.m., LPN 1 indicated the nebulizer mask and humidifier bottle was outdated and should have been		reviewed for all residents using oxygen and addressed immediately Step Three: Nurses and CNAs were re-educated on the importance of changing oxygen supplies on a timely basis as well as the importance of accurate flow rate settings. Step Four: The Director of Nursing or her designee will audit Oxygen supplies and flow rates for all residents 5 times a week for the first four weeks, then four times weekly for the next 4 weeks, then twice weekly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	

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	155667	A. BUILDING 00 B. WING	10/22/2024

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	changed. 2. On 10/16/24 at 10:37 a.m., Resident C was observed sitting in a recliner in her room. The resident had a nasal cannula in place and attached to an oxygen concentrator. The concentrator was set at a flow rate between 2 and 2.5 liters. On 10/16/24 at 3:15 p.m., the Assistant Director of Nursing (ADON) was asked to observe the resident's oxygen flow rate. Resident C was observed sitting in a recliner in her room. The resident had a nasal cannula in place and attached to an oxygen concentrator. The concentrator was set at a flow rate between 2 and 2.5 liters. Record review for Resident C was completed on 10/16/24 at 3:10 p.m. Diagnoses included, but were not limited to, cancer, hypertension, depression, and COPD. The Annual Minimum Data Set (MDS) assessment, dated 8/23/24, indicated the resident was moderately cognitively impaired. The resident required a substantial maximal assistance with dressing and transfers. The resident required oxygen therapy. A Care Plan, dated 6/2/23, indicated the resident had a diagnosis of COPD and used oxygen via nasal cannula. An intervention included for oxygen as ordered. The October 2024 POS indicated an order for oxygen at 3 liters continuously. During an interview on 10/16/24 at 3:15 p.m., the ADON indicated the resident's oxygen was set at 2.5 liters and not at the correct flow rate. 3. Resident D was observed in bed on 10/15/24 at			

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	9:44 a.m. There was an oxygen concentrator near the foot of her bed, which the resident indicated she only used at night. The water bottle in the concentrator was labeled 10/6/24. Resident D's record was reviewed on 10/17/24 at 1:44 p.m. Diagnoses included, but were not limited to, malignant neoplasm of kidney, UTI, pathological fracture, bone cancer, paraplegia, and neuromuscular dysfunction of bladder. The Quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated the resident was cognitively intact. During an interview on 10/15/24 at 11:00 a.m., LPN 1 indicated the water bottle should be changed every week, and that the resident's bottle was outdated. A policy titled, "Oxygen Administration" and received as current from the facility on 10/22/24, indicated, "...4 c. Equipment setting for the prescribed flow rates..." "...5 b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. c. Change humidifier bottle when empty, and weekly per facility policy..." "5 d. If applicable, change nebulizer tubing and delivery devices weekly..." This citation relates to Complaint IN00442131. 3.1-47(a)(6)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote	F 0758	Step One: Interventions and side effects for the psychotropic medications could not be	11/22/2024

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	or maintain the resident's highest practicable mental, physical, and psychosocial well-being related to lack of non-pharmacological interventions used prior to giving anti-anxiety medication and lack of monitoring for side effects of an antidepressant for 2 of 5 residents reviewed for unnecessary medications. (Residents 37 and 48) Findings include: 1. Resident 37's record was reviewed on 10/18/24 at 9:00 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, depression and asthma. The Quarterly Minimum Data Set (MDS) assessment, dated 7/19/24, indicated the resident had significant cognitive impairment and received anti-anxiety medications. A Physician's Order, dated 6/24/24, indicated to give alprazolam (anti-anxiety medication), 0.25 milligrams (mg) every six hours as needed for as needed for anxiety. A Physician's Order, dated 6/21/24, was for an anxiety protocol every shift: 1) Address physical needs 2) Change environment 3) Redirect thoughts 4) All of the above. The September and October 2024 Medication Administration Record (MAR) indicated alprazolam had been given on 9/3, 9/10, 9/21, 9/22 and 10/13. There was no documentation on the MAR or in Progress Notes indicating any non-pharmacological interventions had been attempted prior to giving the medication. During an interview on 10/21/24 at 11:10 a.m., the		amended for the residents identified. Step Two: The medication records of other residents receiving psychotropic medications were reviewed and also could not be amended. Step Three: All nurses were re-educated to the importance of documenting interventions attempted prior to administering a psychotropic medication as well as documentation of side effects following administration. Step Four: The Director of Nursing or her designee will audit the Medication Administration Record for residents receiving psychotropic medications once weekly for the first four weeks, then once every two weeks for the next 4 weeks, then monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	

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	Director of Nursing (DON) provided medication administration notes that indicated non-pharmacological interventions had been attempted on 9/3 and 10/13. There was no documentation for the remaining days. 2. Resident 48's record was reviewed on 10/17/24 at 11:22 a.m. Diagnoses included, but were not limited to, unspecified dementia, depression and multiple sclerosis. The Significant Change MDS, dated 8/29/24, indicated the resident had moderate cognitive impairment and received antidepressant medications. A Physician's Order, dated 8/13/24, indicated to give sertraline (an antidepressant), 100 mg daily for depression. A Physician's Order, dated 8/12/24, indicated to give buproprion (an antidepressant), 150 mg daily for depression. A Psychotropic Medication Care Plan, dated 5/22/24, indicated the resident was at risk for adverse effects related to psychotropic medication that included sertraline and buproprion. Interventions included, but were not limited to, observe for any signs of adverse effects from antidepressant use such as dry mouth, blurred vision, constipation, fatigue and drowsiness. There was no physician's order or documentation in the resident's record to indicate she was being monitored for adverse side effects. During an interview on 10/21/24 at 9:45 a.m., the			

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	DON indicated antipsychotic and antidepressant medication side effects should be monitored every shift and there should be a physician's order in place for that monitoring. She indicated there was not an order in place. The policy, "Psychotropic Medication Policy", revised 8/23/24, indicated, "...7. Residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drug...." The policy also indicated, "...8. Residents who use psychotropic drugs will be observed for side effects of the medication...." and, "...14. The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record...." 3.1-48(a)(3) 3.1-48(b)(2)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review and interview, the facility failed to ensure a sanitary kitchen related to dishwasher temperatures not reaching the required temperature and lack of temperature monitoring for a high temperature dish machine. This had the potential to affect all 52 residents who received meals from the Main Kitchen. Finding includes: The initial kitchen tour was completed on 10/15/24 at 9:00 a.m. with the Dietary Manager (DM). The DM indicated the dishwasher was a high	F 0812	Step One: The Dishwasher was serviced on 10/16/2024 Step Two: No other dishwashers exist that could have a problem. Step Three: All Dietary staff were re-educated on the need to monitor the temperatures for each cycle of the wash and to record that the temperature at the start of washing dishes for each meal as well as what to do when temperatures fall outside of the posted parameters.	10/22/2024

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	temperature dish machine. A wash cycle was observed and the wash temperature was 105 degrees (Fahrenheit) and the rinse was 191 degrees. The DM indicated the wash cycle should be 180 degrees and he was unsure about the rinse cycle. The Dish Machine Temperature Log for October 2024 was reviewed. The log indicated, "High Temperature Machine Wash 160 degrees, Rinse 180 degrees. Report any variations to the Food Service Supervisor or Administrator." Breakfast wash/rinse temperatures were recorded as follows: 10/2- 128/185 10/4- 130/187 10/9- 127/187 10/10-129/134 10/11- 138/187 10/14- 156/176 Lunch temperatures were recorded as follows: 10/14- 178/185 Dinner temperatures were recorded as follows: 10/2- 180/183 10/3- 181/185 10/5- 181/187 10/6- 180/187 10/9- 129/134 10/10- 129/134 10/11- 118/184 There were no additional temperatures recorded for breakfast, lunch or dinner in October. During an interview on 10/22/24 at 3:05 p.m., the DM indicated the manufacturer had come to the facility on Tuesday to reset the dishwasher and		Step Four: The Dietary Manager or his designee will audit documentation of dishwasher temps daily for the first 4 weeks, then 5 times a week during weeks 5-8, then three times a week during weeks 9-26. Audit results will be reported to QAPI monthly. The QAPI team will determine if the plan should be amended or discontinued.	

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	temperatures were now in range. The policy, "Dishwasher Temperature", indicated, "...Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or refilled for cleaning purposes." 3.1-21(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to the lack of a resident's name on a self-medication administration assessment for 1 of 5 residents reviewed for unnecessary medications. (Resident 23) Finding includes: The record for Resident 23 was reviewed on 10/16/24 at 2:46 p.m. Diagnoses included, but were not limited to, repeated falls, hemiplegia (paralysis on one side of the body) due to a stroke, aphasia (loss of language use), hypertension, and right foot drop. The Quarterly Minimum Data Set (MDS) assessment, dated 8/6/24, indicated the resident had moderate cognitive impairment, and required set up assistance for most activities of daily living. A Physician's Order, dated 8/2/24, indicated the resident could self-administer Econazole nitrate powder (an antifungal medication) topically, twice daily to the groin and scrotum.	F 0842	Step One: The name was added to the self-administration of medication assessment for the resident identified. Step Two: All other self-administration assessments were audited to verify the resident's name was included. Step Three: All nursing staff were re-educated to the importance of including the resident's name on assessment documents. Step Four: The Director of Nursing or her designee will audit self administration assessments once weekly for the first four weeks, then once every two weeks for the next 4 weeks, then monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	11/22/2024

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	A Self-Administration of Medication Evaluation, dated 8/2/24 and received from the Assistant Director of Nursing (ADON), failed to document a resident's name. During an interview on 10/21/24 at 3:30 p.m., the ADON indicated the evaluation was for Resident 23, but she accidentally wrote her own name on the form instead of his. 3.1-50(a)(1)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility failed to ensure infection control guidelines were in place and implemented related to hand hygiene and glove use during a wound treatment for 1 of 1 treatments observed. (Wound Care Nurse and Resident 20) Finding includes: During an observation of Resident 20's wound care on 10/21/24 at 10:54 a.m., the Wound Care Nurse was observed changing the dressings on the right heel, right ankle, and right lower leg. She entered the room, washed her hands with soap and water, and donned a gown and gloves. She removed the old dressings from the right lower leg, right ankle, and right heel, each dated 10/19/24. She removed her gloves and donned new gloves, without performing hand hygiene between glove use. She sprayed wound cleanser to gauze and cleaned the right lower leg and then threw away the gauze. She removed more gauze, sprayed it with wound cleanser and cleaned the right ankle. She removed more gauze, sprayed it	F 0880	Step One: the nurse identified was re-educated. Step Two: No other issues were identified. Step Three: All nursing staff were re-educated to the importance of proper infection control procedures. Step Four: The Director of Nursing or her designee will audit infection control practices during treatments once weekly for the first four weeks, then once every two weeks for the next 4 weeks, then monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	11/22/2024

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	with wound cleanser and cleaned the right heel. She did not perform hand hygiene or change gloves between caring for each wound. She opened a foam dressing, reached into her pocket and removed a marker, wrote the date on the foam dressing, and continued to perform wound care without sanitizing her hands and changing gloves. She applied honey wound gel to the foam dressing and placed it over the right heel wound. She continued to apply the dressings to the right ankle and right lower leg by putting drops of Tetracyte (topical antibiotic) to the open areas, an oil emulsion dressing, and then a calcium alginate dressing over the top with rolled gauze to hold the dressing in place. She dated the dressing, removed her gloves, and washed her hands. During an interview on 10/21/24 at 11:26 a.m., the Wound Care Nurse indicated she was supposed to do hand hygiene between glove use, put on new gloves between caring for each wound, and she should have changed gloves after reaching into her pocket. During an interview on 10/22/24 at 12:57 PM, the Administrator indicated she had no further information to provide. A corresponding policy was requested at the time, but was never received. 3.1-18(b)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: October 15, 16, 17, 18, 21, and 22, 2024	R 0000	This Plan of Correction shall serve as this facility's credible allegation of compliance. Completion and implementation of this plan is not a confirmation of the statements and facts set out in this survey,	

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	Facility number: 010823 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/29/24.		but rather an effort to continually improve services to our residents. Please consider allowing submission of education and audits as proof of compliance. Respectfully Submitted Beth Ingram VP of Operations Oak Grove Christian Retirment Village	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on record review and interview, the facility failed to ensure semi-annual evaluations were completed for 2 of 7 records reviewed. (Residents 2 and 3) The facility also failed to ensure self medication assessments were completed for 1 of 7 records reviewed. (Resident 6) Findings include: 1. Resident 2's record was reviewed on 10/21/24 at 1:05 p.m. Diagnoses included, but were not limited to muscle weakness and intravertebral disc degeneration. The resident was admitted to the facility on 1/31/23. The record lacked documentation that a semi-annual evaluation had been completed. 2. Resident 3's record was reviewed on 10/22/24 at 9:20 a.m. Diagnoses were unavailable. The resident was admitted to the facility on 12/15/22. The record lacked documentation that a semi-annual evaluation had been completed.	R 0216	Step One: The semiannual evaluation/Self Administration Assessment was completed for the residents identified. Step Two: All Assisted Living resident records were audited to assure the semiannual evaluation/ Self Administration Assessments were completed. Evaluations were updated for any that were found missing. Step Three: Nursing Leadership and Assisted Living Nurses were re-educated to the importance of completing the semiannual evaluation/Self Administration Assessment Step Four: The Director of Nursing or her designee will audit Semiannual evaluations/Self Administration Assessments once weekly for the first four weeks, then once every two weeks for the	11/22/2024

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	During an interview on 10/22/24 at 3:18 p.m., Medical Records indicated she was unable to locate semi-annual evaluations for Residents 2 and 3. 3. Resident 6 was observed resting in a recliner on 10/22/24 at 2:30 p.m. A large bottle of Acetaminophen was observed on her table. The resident indicated she took the Acetaminophen when she felt like she needed it, and let the staff know whenever she took it. The record for Resident 6 was reviewed on 10/22/24 at 9:18 a.m. Diagnoses included, but were not limited to, respiratory failure, congestive heart failure, and chronic atrial fibrillation. The resident's current Service Plan, updated 6/5/24, indicated she required a health care professional to administer pills. During an interview on 10/22/24 at 2:50 p.m., the Assistant Director of Nursing (ADON) indicated the resident did not self-administer pills, and she did not know the resident had the bottle of Acetaminophen, but she would look into it.		next 4 weeks, then monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on observation, record review and interview, the facility failed to ensure Service Plans were completed and/or updated related to urinary catheter management, wound care and insulin use for 4 of 7 resident records reviewed. (Residents 2, 3, 4 and 5) Findings include: 1. Resident 2's record was reviewed on 10/21/24 at 1:05 p.m. Diagnoses included, but were not limited	R 0217	Step One: The Service Plans identified were updated to address the new needs. Step Two: All Resident's Service Plans were reviewed to assure accuracy and updated if needed. Step Three: Nursing staff were re-educated to the importance of updating each resident's service	10/22/2024

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	to muscle weakness and intravertebral disc degeneration. The resident was admitted to the facility on 1/31/23. A current Physician's Order indicated the resident had a indwelling catheter for urinary retention and it may be changed for leakage, occlusion or dislodgement. A Progress Note, dated 6/24/24, indicated the facility nurse had spoken with a home health nurse who informed her the resident's catheter had been changed on 6/20/24 and was scheduled to be changed again on 7/18/24. A Progress Note, dated 8/30/24, indicated a home health nurse had inserted an indwelling catheter. The resident's Service Plan, dated 12/13/23, indicated the resident had an indwelling catheter and she emptied it herself. The Service Plan did not indicate a home health nurse was to manage the catheter or the frequency to be changed. During an interview on 10/21/24 at 3:10 p.m., the Director of Nursing (DON) had no additional information related to the Service Plan. 2. On 10/22/24 at 10:45 a.m., Resident 3 was observed seated in his room. His right leg was wrapped with a dressing and he had it elevated on a stool. He indicated he had some ulcers on his leg and a home health nurse was visiting to treat it. Resident 3's record was reviewed on 10/22/24 at 9:20 a.m. Diagnoses were unavailable. The resident was admitted to the facility on 12/15/22. A Progress Note, dated 10/10/24, indicated the		plan as their needs change. Step Four: The Director of Nursing or her designee will audit 4 Service Plans once weekly for the first four weeks, then 4 every two weeks for the next 4 weeks, then 4 monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	

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	155667	A. BUILDING 00 B. WING	10/22/2024

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	resident had an open area on his right calf described as a partial blister, some edema, and weeping of the leg was also noted. The physician was notified, the area was treated with bacitracin and covered with a dressing. A Progress Noted, dated 10/13/24, indicated the resident continued to receive treatment to right calf. There were no further progress notes after this date. There was no physician's order for home health to treat the wound. A Service Plan, dated 7/18/23, indicated the resident did not require any services for Physical Health, that included assistance with skin care, including treatment and dressings. During an interview on 10/22/24, the Assistant DON provided copies of the Service Plan and Physician's Orders, but had no additional information available. 3. Resident 4's record was reviewed on 10/22/24 at 11:10 a.m. Diagnoses included, but were not limited to chronic kidney disease and hypertension. The resident was admitted on 9/5/24. The record lacked a Service Plan for the resident. During an interview on 10/22/24 at 3:25 p.m., Medical Records indicated she was unable to locate a Service Plan. 4. Resident 5's record was reviewed on 10/22/24 at 9:58 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and cerebral infarction. The October 2024 Physician Order Summary			

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	indicated the resident received 30 units of Basaglar insulin 100 unit/milliliter daily and required twice daily blood sugar monitoring. The most recent Service Plan, dated 9/19/24, indicated the resident was independent for daily decision making, required health care professional to administer injections, pills, or liquids, and had no behavioral problems. The Service Plan did not address blood sugar monitoring or insulin injections. During an interview on 10/22/24 at 2:14 p.m., the Administrator indicated she had no further information to provide.			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency Based on record review and interview, the facility failed to ensure qualified medication aides (QMAs) received authorization from a licensed nurse or physician prior to giving as needed (PRN) medications, for 2 of 7 records reviewed. (Residents 6 and 5) Findings include: 1. Record review for Resident 6 was completed on 10/22/24 at 9:18 a.m. Diagnoses included, but were not limited to, respiratory failure, congestive heart failure, and chronic atrial fibrillation. The October 2024 Medication Administration Record (MAR) indicated QMA 1 administered a PRN dose of ondansetron 4 mg (antinausea medication) to the resident. There was a lack of documentation to indicate the	R 0246	Step One: The QMA identified was re-educated of the need to have a nurse assess a resident and give permission for a PRN medication to be administered. Step Two: The other resident's PRN medication records were reviewed an no other errors were found. Step Three: QMAs and Nurses were re-educated to the importance of a nurse evaluating the need for a PRN medication prior to a QMA administering the PRN medication. Step Four: The Director of Nursing or her designee will audit 5 PRN	11/11/2024

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	QMA had received authorization from a licensed nurse or physician prior to administering the medication. During an interview on 10/22/24 at 3:55 p.m., the Director of Nursing (DON) indicated the PRN medications were supposed to be documented in a progress note for prior authorization before administering them, or co-signed by an RN or LPN on the MAR. She was unable to provide any documentation the prior authorization had been completed.2. Resident 5's record was reviewed on 10/22/24 at 9:58 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and cerebral infarction. The most recent Service Plan, dated 9/19/24, indicated the resident was independent for daily decision making and required health care professional to administer injections, pills, or liquids. The October 2024 Physician Order Summary indicated Tylenol 500 milligrams (mg) 2 tablets by mouth every 8 hours as needed for analgesic and ibuprofen 600 mg by mouth every 6 hours as needed for pain. The October 2024 Medication Administration Record (MAR) indicated Tylenol was signed out as administered by QMA 1 on 10/11/24 at 1:45 p.m. and 10/19/24 4:55 p.m. Ibuprofen was signed out as administered by QMA 1 on 10/10/24 at 3:36 p.m. and 10/11/24 at 6:22 p.m. During an interview on 10/22/24 at 2:14 p.m., the Administrator indicated she was unable to locate documentation regarding prior authorization for the QMA to administer an as needed medication.		medication administration records once weekly for the first four weeks, then 5 records once every two weeks for the next 4 weeks, then 5 records monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	

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R 0273 Bldg. 00	A policy titled, "PRN Medication Policy," indicated "...PRN medications are administered by staff who are legally authorized to do so through certification or licensure, in accordance with a physician's order." 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, record review and interview, the facility failed to ensure a sanitary kitchen related to dishwasher temperatures not reaching the required temperature and lack of temperature monitoring for a high temperature dish machine. This had the potential to affect all 29 residents that received meals from the Main Kitchen. Finding includes: The initial kitchen tour was completed on 10/15/24 at 9:00 a.m. with the Dietary Manager (DM). The DM indicated the dishwasher was a high temperature dish machine. A wash cycle was observed and the wash temperature was 105 degrees (Fahrenheit) and the rinse was 191 degrees. The DM indicated the wash cycle should be 180 degrees and he was unsure about the rinse cycle. The Dish Machine Temperature Log for October 2024 was reviewed. The log indicated, "High Temperature Machine Wash 160 degrees, Rinse 180 degrees. Report any variations to the Food Service Supervisor or Administrator." Breakfast wash/rinse temperatures were recorded as follows: 10/2- 128/185	R 0273	Step One: The Dishwasher was serviced on 10/16/2024 Step Two: No other dishwashers exist that could have a problem. Step Three: All Dietary staff were re-educated on the need to monitor the temperatures for each cycle of the wash and to record that the temperature at the start of washing dishes for each meal as well as what to do when temperatures fall outside of the posted parameters. Step Four: The Dietary Manager or his designee will audit documentation of dishwasher temps daily for the first 4 weeks, then 5 times a week during weeks 5-8, then three times a week during weeks 9-26. Audit results will be reported to QAPI monthly. The QAPI team will determine if the plan should be amended or discontinued.	10/22/2024

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	10/4- 130/187 10/9- 127/187 10/10-129/134 10/11- 138/187 10/14- 156/176 Lunch temperatures were recorded as follows: 10/14- 178/185 Dinner temperatures were recorded as follows: 10/2- 180/183 10/3- 181/185 10/5- 181/187 10/6- 180/187 10/9- 129/134 10/10- 129/134 10/11- 118/184 There were no additional temperatures recorded for breakfast, lunch or dinner in October. During an interview on 10/22/24 at 3:05 p.m., the DM indicated the manufacturer had come to the facility on Tuesday to reset the dishwasher and temperatures were now in range. The policy, "Dishwasher Temperature", indicated, "...Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or refilled for cleaning purposes."			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure resident records were accurate and complete related to lack of medical diagnoses, lack of a physician's order for home health care and lack of physician notification of blood	R 0349	Step One: The medical records of those identified have been updated to reflect the accurate medical diagnosis, home health orders as well as physician notification of	11/22/2024

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	glucose levels outside of parameters for 2 of 7 resident records reviewed. (Residents 3 and 5) Findings include: 1. On 10/22/24 at 10:45 a.m., Resident 3 was observed seated in his room. His right leg was wrapped with a dressing and he had it elevated on a stool. He indicated he had some ulcers on his leg and a home health nurse was visiting to treat it. Resident 3's record was reviewed on 10/22/24 at 9:20 a.m. Diagnoses were unavailable. The resident was admitted to the facility on 12/15/22. A Progress Note, dated 10/10/24, indicated the resident had an open area on his right calf described as a partial blister, some edema and weeping of the leg was also noted. The Physician was notified, the area was treated with bacitracin and covered with a dressing. A Progress Note, dated 10/13/24, indicated the resident continued to receive treatment to right calf. There were no further Progress Notes after this date. The Electronic Treatment Administration Record indicated treatments discontinued on 10/20/24. There was no physician's order for home health to treat the wound. Resident diagnoses were requested on three occasions and not provided. During an interview on 10/22/24, the Assistant Director of Nursing provided copies of the Service Plan and Physician's Orders, but had no additional information available.		blood glucose outside of prescribed parameters. Step Two: All Assisted Living residents medical records were audited to assure accuracy. Step Three: All nurses were re-educated to the importance of an accurate medical records as well as the importance of physician notification when Blood glucose is outside of prescribed parameters. Step Four: The Director of Nursing or her designee will audit the 5 assisted living medical records once weekly for the first four weeks, then 5 records once every two weeks for the next 4 weeks, then 5 monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	

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	2. Resident 5's record was reviewed on 10/22/24 at 9:58 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and cerebral infarction. The most recent Service Plan, dated 9/19/24, indicated the resident was independent for daily decision making, required health care professional to administer injections, pills, or liquids, and had no behavioral problems. The October 2024 Physician Order Summary indicated the resident received 30 units of Basaglar insulin 100 unit/milliliter daily, required twice daily blood sugar monitoring, and required notification to the Physician if the blood sugar was less than 70 or greater than 400. The September and October 2024 Medication Administration Records indicated the resident had blood sugars outside of the parameters and required notification to the Physician on the following dates and times: - 9/15/24 at 6:00 a.m., blood sugar: 64 - 9/23/24 at 6:00 a.m., blood sugar was blank - 9/27/24 at 6:00 a.m., blood sugar: 64 - 9/29/24 at 4:00 p.m., blood sugar was blank - 10/2/24 at 6:00 a.m., blood sugar: 51 - 10/2/24 at 4:00 p.m., blood sugar was blank - 10/9/24 at 6:00 a.m., blood sugar: 57 - 10/11/24 at 6:00 a.m., blood sugar: 62 - 10/19/24 at 6:00 a.m., blood sugar was blank - 10/20/24 at 6:00 a.m., blood sugar was blank - 10/29/24 at 4:00 p.m., blood sugar was blank There was no documentation to indicate the Physician was notified when the blood sugar was less than 70. During an interview on 10/22/24 at 2:14 p.m., the Administrator indicated she had no further			

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	information to provide and was unable to locate any documentation the Physician was notified.			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure the resident Emergency Binder contained all the necessary information for 3 of 5 residents reviewed. (Residents 2, 3 and 4) Findings include: The resident Emergency Binder was reviewed on 10/22/24 at 8:45 a.m.. The following information was missing: a. Resident 2 - missing hospital preference. b. Resident 3 - missing hospital preference and emergency contact information. c. Resident 4 - missing hospital preference and emergency contact information. During an interview on 10/22/24, the Social Service Director indicated the above information was available in the electronic record, she was not aware it had to be in the Emergency Binder.	R 0356	Step One: The emergency binders for the identified residents were updated. Step Two: All Assisted living residents emergency binders were reviewed to verify all required information is present. Step Three: Nursing staff were re-educated on the importance of maintaining an accurate and up to date record in the emergency binder. Step Four: The Director of Nursing or her designee will audit 5 emergency binders once weekly for the first four weeks, then 5 once every two weeks for the next 4 weeks, then 5 monthly for the next 16 weeks. Results will be reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	11/22/2024