STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155667		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/22/2024	
	PROVIDER OR SUPPLIE		221 W	ADDRESS, CITY, STATE, ZIP COD DIVISION ST	
OAK GR	ROVE CHRISTIAN	RETIREMENT VILLAGE	DEMO	TTE, IN 46310	
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000 Bldg. 00					
	This visit was for	a Recertification and State	F 0000	This Plan of Correction shall s	erve
	Licensure Survey	and the Investigation of		as this facility's credible allega	tion
	Complaint IN00442131. This visit included a State Residential Licensure Survey.			of compliance. Completion and	d
				implementation of this plan is a confirmation of the statemen	
	Complaint IN0044	42131 - Federal/State deficiencies		and facts set out in this survey	
	^	gations are cited at F695.		but rather an effort to continua	
				improve services to our reside	
	Survey dates: Octo	ober 15, 16, 17, 18, 21, and 22,		Please consider allowing	
	2024			submission of education and	
				audits as proof of compliance.	
	Facility number: (Respectfully Submitted	
	Provider number: AIM number: 200			Beth Ingram	
	Alvi number: 200	1230030		VP of Operations Oak Grove Christian Retirmen	+
	Census Bed Type:			Village	
	SNF/NF: 44	•		Village	
	SNF: 8				
	Residential: 29				
	Total: 81				
	Census Payor Typ	e:			
	Medicare: 8				
	Medicaid: 26				
	Other: 18				
	Total: 52				
	These deficiencies accordance with 4	s reflect State Findings cited in 10 IAC 16.2-3.1.			
	Quality review co.	mpleted on 10/29/24.			
F 0623	483.15(c)(3)-(6)(8)			
SS=D	Notice Requirem				
Bldg. 00	Transfer/Dischar				
		eview and interview, the facility	F 0623	Step One: The required notice	was 11/22/2024
	failed to ensure a	resident and/or their		resent to the resident and fam	ily
	I NA DIDECTOR :	OVAIDED (AVIDD) AND		<u></u>	
		OVIDER/SUPPLIER REPRESENTATIVE'S		TITLE	(X6) DATE
Beth Ingra	am		Adminis	trator	11/11/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155667	B. WI	NG		10/22/	2024
NAME OF B			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	C			DIVISION ST		
OAK GR	OVE CHRISTIAN R	ETIREMENT VILLAGE		DEMOT	ГТЕ, IN 46310		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		were notified in writing related nospital for 1 of 2 residents			and a copy retained for our		
		-			records.		
	reviewed for hospitalization. (Resident 15) Finding includes:				Step Two: The discharge		
					notifications of recent transfer	9	
					and discharges was reviewed		
	Resident 15's record	d was reviewed on 10/17/24 at			any missing transfer notification		
		s included, but were not limited			were resent with a copy retain		
	_	betes mellitus and fluid					
	overload.				Step Three: Nursing Staff wer	е	
					re-educated to the importance		
		mum Data Set assessment,			retaining proof that the notice	of	
		cated the resident was			transfer and discharge was given	ven	
	significantly impair	red for daily decision making.			prior to transfer to the hospital	l.	
	Progress Notes indi	cated the resident was sent to			Step Four: The Social Service	ie.	
	-	24 and returned to the facility			Director or her Designee will a		
	on 8/29/24.	72 I and retarned to the facility			the medical record to verify the		
	on 0.23.2				notice of transfer or discharge		
	There was no docur	nentation to indicate the State			been retained once weekly for		
		orm was completed and sent			first four weeks, then once eve		
	with the resident.				two weeks for the next 4 week	-	
					then monthly for the next 16		
		mentation to indicate the			weeks. Results will be reporte	d to	
		ble Party had received written			QAPI monthly. the QAPI team	will	
		esident's transfer to the			determine if the Plan requires		
	hospital.				amendment or may be		
	D	10/17/24 4 0 20			discontinued.		
	-	v on 10/17/24 at 9:20 a.m., RN 4					
		dents were sent out to the sent with a face sheet, a copy					
		ld policy and transfer/					
		opies were made and given to					
	medical records.	opies were made and given to					
	During an interview	v on 10/17/24 at 2:20 p.m., the					
	-	indicated they were unable to					
	locate the State app	roved transfer form.					
	3.1-12(a)(6)(A)(ii)						

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SENTERS FOR	MEDICARE & MEDIC	EAID SERVICES			OMB NO. 0938-039	
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155667	B. WING		10/22/2024	
	PROVIDER OR SUPPLIES		221 W	ADDRESS, CITY, STATE, ZIP COD DIVISION ST		_
OAK GRO	JVE CHRISTIAN R	RETIREMENT VILLAGE	DEMO	TTE, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	_
	3.1-12(a)(6)(A)(iii)					
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hol	d Policy Before/Upon Trnsfr				
	Based on record rev	view and interview, the facility	F 0625	Step One: The bed hold policy	y 11/22/2024	
	failed to ensure a re			was sent to the resident identi		
		were sent the facility's bed hold		and a copy retained for record	1.	
		yment policy before and upon				
	_	ital for 1 of 2 residents		Step Two: the records of resid	I	
reviewed for hospitalization. (Resident 15)		alization. (Resident 13)		recently transferred or dischar were reviewed and notice was	•	
	Finding includes:			issues if not found in the recor		
	Resident 15's record	d was reviewed on 10/17/24 at		Step Three: Nursing staff were	e	
	9:50 a.m. Diagnose	es included, but were not limited		re-educated to the importance	I	
		betes mellitus and fluid		retaining a copy of the bed ho	I	
	overload.			policy prior to transferring to the hospital.	ne	
	The Quarterly Mini	imum Data Set assessment,				
	·	cated the resident was		Step Four: The Social Service	:s	
	significantly impair	red for daily decision making.		Director or her designee will a	I	
				that a copy of the bed hold po	-	
		icated the resident was sent to		was retained prior to transfer t	I	
	on 8/29/24.	1/24 and returned to the facility		the hospital once weekly for the	I	
	011 6/29/24.			first four weeks, then once even two weeks for the next 4 week		
	There was no docu	mentation to indicate the		then monthly for the next 16	ιδ,	
		policy was completed and sent		weeks. Results will be reporte	ed to	
	with the resident.			QAPI monthly. the QAPI team		
				determine if the Plan requires	I	
	There was no docur	mentation to indicate the		amendment or may be		
	_	ble Party had received written		discontinued.		
	notification of the f	acility's bed hold policy.				
	Duning on intern	rr on 10/17/24 at 0/20 DN 4				
		v on 10/17/24 at 9:20 a.m., RN 4 dents were sent out to the				
		sent with a face sheet, a copy				
		old policy and transfer/				

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discharge papers. Copies were made and given to

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 10/22/2024				
		155667	B. W.			10/22/	12024
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP COD		
OAK GR	OVE CHRISTIAN R	ETIREMENT VILLAGE	_		TTE, IN 46310		,
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	medical records.	CESC IDENTIFY THAT IN CRAMMITTEN		1110			DATE
	During an interview	on 10/17/24 at 2:20 p.m., the indicated they were unable to policy.					
F 0640 SS=A Bldg. 00	483.20(f)(1)-(4) Encoding/Transmi Assessments Based on record rev failed to successfull Minimum Data Set manner for 1 of 22	view and interview, the facility ly complete and export the (MDS) assessment in a timely residents whose MDS eviewed. (Resident 27)	F 00	540	No Plan of Correction is require for a level A citation.	red	10/22/2024
	Finding includes:						
	10/18/24 at 2:33 p.r not limited to, pneu	dent 27 was reviewed on m. Diagnoses included, but were monia and type 2 diabetes ent admitted to the facility on charged on 9/27/24.					
	assessment, dated 9	turn Not Anticipated MDS /27/24, indicated it was not itted as of the review date.					
	Administrator indic information to prov	on 10/22/24 at 2:14 p.m., the ated she had no further ide. The facility was going thru DS Coordinators and it was					
	"Policy Implement Assessmentsf. Discompleted using the	DS 3.0 Completion," indicated nation2. Types of OBRA scharge Assessment - e discharge date as the ARD. within 14 days of the					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155667		r í	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 00 COMPLETE B. WING 10/22/202			
	PROVIDER OR SUPPLIER	ETIREMENT VILLAGE	221	EET ADDRESS, CITY, STATE, ZIP (1 W DIVISION ST MOTTE, IN 46310	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
F 0641 SS=A Bldg. 00			F 0641	No Plan of Correction for a level A citation.	is required	10/22/2024
	comprehensive asse completed related to assessment complet	essment was accurately a section GG functional cion and intravenous (IV) as of 22 MDS assessments		ior a level A citation.		
	at 2:27 p.m. Diagno	ord was reviewed on 10/16/24 uses included, but were not obstructive pulmonary disease,				
	indicated the reside	ssessment, dated 9/4/24, nt was cognitively intact. indicated the functional level of				
	Director of Nursing been completed. Th information provide 2. Resident D was 9:44 a.m. Snacks ar bedside. There were	on 10/17/24 at 10:58 a.m., the indicated section GG had not ere was no additional ed. observed in bed on 10/15/24 at addrinks were observed at her e no IV supplies or equipment esident indicated she ate a				
	Resident D's record 1:44 p.m. Diagnoso limited to, malignar tract infection, path	was reviewed on 10/17/24 at es included, but were not nt neoplasm of kidney, urinary ological fracture, bone cancer, romuscular dysfunction of				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155667		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/22/2024			
		100001			10/22/2024
	PROVIDER OR SUPPLIER OVE CHRISTIAN R	ETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP COD 221 W DIVISION ST DEMOTTE, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	bladder.				
	assessment, dated 8 was cognitively intareceived parenteral During an interview Director of Nursing received parenteral coded in error. 3. Rereviewed on 10/18/2 included, but were robstructive pulmonary	mum Data Set (MDS) /27/24, indicated the resident act, and that the resident was (IV) nutrition. y on 10/22/24 at 2:55 p.m., the indicated the resident had not nutrition, and the MDS was esident 211's record was 24 at 9:16 a.m. Diagnoses not limited to, chronic ary disease, Alzheimer's e of the right leg above the			
	assessment, dated 9 was cognitively inta Section GG - Activi capabilities was not	•			
		on 10/22/24 at 2:14 p.m., the ated she had no further ide.			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing				
-	interview, the facility were reviewed and related to IV (intrav	on, record review, and ty failed to ensure care plans revised to include changes renous) fluids for 1 of 22 reviewed. (Resident D)	F 0657	Step One: The plan of care for resident identified was updated. Step Two: The care plans of a residents were audited to ass accuracy and updated as need.	all ure ded.
		erved in bed on 10/15/24 at re no IV supplies or equipment		Step Three: Nursing staff wer re-educated on the importance amending the plan of care as	e of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155667			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/22/2024	
	PROVIDER OR SUPPLIE	RETIREMENT VILLAGE	221 W	ADDRESS, CITY, STATE, ZIP COD DIVISION ST TTE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F 0684	had an IV since ret hospital on 9/14/24 Resident D's recor 1:44 p.m. Diagnos limited to, malignatract infection, pat paraplegia, and net bladder. The Quarterly Mir assessment, dated was cognitively in A Care Plan, dated needed IV fluids for included, but were fluids, monitor IV complete flushes puring an intervie Director of Nursin was not receiving would need to be residued.	d was reviewed on 10/17/24 at ses included, but were not ant neoplasm of kidney, urinary nological fracture, bone cancer, aromuscular dysfunction of the imum Data Set (MDS) 8/27/24, indicated the resident fact. 9/14/24, indicated the resident for dehydration. Interventions not limited to, administer IV site and arm every shift, and er orders. sician's Orders for IV fluids. w on 10/22/24 at 2:55 p.m., the g (DON) indicated the resident IV fluids, and the care plan		needs change. Step Four: The Director of No or her designee will audit can plans related to an IV once w for the first four weeks, then devery two weeks for the next weeks, then monthly for the repto QAPI monthly. the QAPI to will determine if the Plan requamendment or may be discontinued.	e eekly once 4 eext orted eam	
SS=D Bldg. 00	failed to ensure pa Physician notificat monitoring for a re	view and interview, the facility rameters were in place for ion related to weight sident with three times a week resident reviewed for edema.	F 0684	Step One: The physician order was updated for the resident identified. Step Two: All other orders for weight monitoring were audit accuracy and updated if need	ed for	

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11/19/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/22/2024 155667 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 221 W DIVISION ST OAK GROVE CHRISTIAN RETIREMENT VILLAGE DEMOTTE, IN 46310 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Finding includes: Step Three: All nursing staff were Resident 15's record was reviewed on 10/17/24 at re-educated on the importance of 9:50 a.m. Diagnoses included, but were not limited including parameters when to, heart failure, diabetes mellitus and fluid obtaining an order to monitor overload. weight. The Quarterly Minimum Data Set assessment, Step Four: The Director of Nursing dated 7/27/24, indicated the resident was or her designee will audit significantly impaired for daily decision making. physician's orders for weight monitoring to assure parameters A Physician's Order, dated 4/22/24, indicated to are in place once weekly for the weigh the resident every Monday, Wednesday first four weeks, then once every and Friday related to congestive heart failure. two weeks for the next 4 weeks, There were no parameters in place for when to then monthly for the next 16 notify the Physician of a change in weight. weeks. Results will be reported to QAPI monthly. the QAPI team will The current Fluid Maintenance Care Plan determine if the Plan requires indicated the resident was at risk for fluid volume amendment or may be overload due to congestive heart failure. discontinued. 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...."

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155667		A. BU	A. BUILDING <u>00</u>		COMPI	x3) date survey Completed 10/22/2024	
	PROVIDER OR SUPPLIER	ETIREMENT VILLAGE		221 W [ADDRESS, CITY, STATE, ZIP COD DIVISION ST TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0686 SS=D Bldg, 00		Prevent/Heal Pressure					
Bldg. 00	Ulcer Based on observation interview, the facility with pressure ulcers services necessary the updating and follow wound care for 1 of pressure ulcers (Restricted in the pressure ulcers). During an observation care on 10/21/24 at Nurse was observed the right heel, right entered the room, when and water, and donor removed the old dread leg, right ankle, and 10/19/24. She remover the facility of the removed the right ankle, and 10/19/24. She removed the facility of the removed the remove	on, record review, and ty failed to ensure a resident received the treatment and o promote healing related to ring Physician's Orders for 3 residents reviewed for	F 06	586	Step One: The treatment plan the resident identified was up to match the new orders. Step Two: All other wound or were audited to verify that treatment plans match physic orders. Step Three: Nursing Staff were-educated on the important updating treatment plans as physician's orders and amend Step Four: The Director of Nu or her designee will audit would orders once weekly for the first four weeks, then once every tweeks for the next 4 weeks, the monthly for the next 16 weeks	dated ders ian re ee of ded. ursing und st two	11/22/2024
	between glove use. to gauze and cleane threw away the gaus sprayed it with wou right ankle. She rem with wound cleanse She opened a foam pocket and removed the foam dressing, a wound care. She ap foam dressing and p wound. She continu the right ankle and a drops of Tetracyte (areas, an oil emulsica alginate dressing ov	She sprayed wound cleanser d the right lower leg and then ze. She removed more gauze, and cleanser and cleaned the noved more gauze, sprayed it ar and cleaned the right heel. dressing, reached into her d a marker, wrote the date on and continued to perform plied honey wound gel to the placed it over the right heel led to apply the dressings to right lower leg by putting topical antibiotic) to the open on dressing, and then a calcium ter the top with rolled gauze to place. She dated the dressing,			Results will be reported to QA monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	API	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155667	B. WI	ING		10/22	/2024
NAME OF P	PROVIDER OR SUPPLIE	R.			ADDRESS, CITY, STATE, ZIP COD		
		RETIREMENT VILLAGE			DIVISION ST FTE, IN 46310		
			-		i i ⊑, IIN 403 IU I		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION DATE
IAG		s, and washed her hands.		IAG			DATE
	remeved her greve	o, and washed her hands.					
	Resident 20's recor	rd 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						
	, ,	gnificantly impaired for daily					
	decision making. H	Ie required assistance from staff					
	for transfers and be	ed mobility.					
	A Physician's Order, dated 9/26/24, indicated apply medical grade honey gel to right heel and						
		gauze on Tuesday, Thursday,					
	and Saturday.	gauze on Tuesday, Thursday,					
	ana Sataraay.						
	A Wound Care Pro	ogress Report, dated 10/10/24,					
	indicated the reside	ent had an unstageable right					
	-	e ulceration measuring 4.5					
		y 3.5 cm by 0.1 cm. Treatment					
		apply Tetracyte to the wound					
	-	nedical grade honey and calcium					
	_	wound with bordered gauze d for soiled or loose dressing.					
	daily and as needed	for solled or loose dressing.					
	During an interview	w on 10/21/24 at 11:26 a.m., the					
	_	e indicated the wound care was					
	ordered for three ti	mes a week. She was unaware					
	of daily treatment of	changes.					
	During an interview	w on 10/22/24 at 2:14 p.m., the					
	-	cated she had no further					
	information to prov						
	-						
		ound Treatment Policy,"					
		und treatments will be provided					
		physician orders, including the					
	cleansing method,	type of dressing, and	I				I

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155667		A. BUILDING 00 B. WING		COMPLETED 10/22/2024	
		100007	D. W.	_		10/22/	2U2 4
	PROVIDER OR SUPPLIER	ETIREMENT VILLAGE		221 W I	ADDRESS, CITY, STATE, ZIP COD DIVISION ST ITE, IN 46310		
OAK GK	OVE CHRISTIAN K	ETIKEWENT VILLAGE		DEIVIO			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	frequency of dressing			IAG			DATE
	1 3						
	3.1-40(a)(2)						
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Inc	continence, Catheter, UTI					
Bldg. 00	interview, the facilitindwelling Foley (u for a resident with a covered and not har can for 1 of 1 reside catheters. (Residen Finding includes: On 10/16/24 at 10:3 observed sitting in a resident's urinary cathanging off the top to her. The uncover and the side of the gwas observed with to On 10/16/24 at 3:15 Nursing (ADON) we resident's catheter be sitting in a recliner furinary catheter bag off the top of a garb. The uncovered bag side of the garbage observed with trash.	arecliner in her room. The atheter bag was uncovered and of a garbage can sitting next ared bag was touching the top garbage can. The garbage can areash in the can. The p.m., the Assistant Director of as asked to observe the ag. Resident C was observed in her room. The resident's awas uncovered and hanging age can sitting next to her. was touching the top and the can. The garbage can was	F 00	690	Step One: A cover was obtain and the bag was relocated for resident identified. Step Two: The catheters for a other residents were observed addressed as needed. Step Three: Nurses and CNAs be re-educated on the importation of covering the catheter bad a well as placement of the bag. Step Four: The Director of Nuror her designee will audit resident's catheters three times weekly for the first four weeks then once every week for the 4 weeks, then monthly for the 16 weeks. Results will be report to QAPI monthly. the QAPI tea will determine if the Plan requiremendment or may be discontinued.	the II d and s will ance s rsing es next next next orted am	11/22/2024
	were not limited to,	cancer, hypertension, PD (chronic obstructive					

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Event ID:

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Facility ID: 010823

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155667		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/22/2024	
	PROVIDER OR SUPPLIER	ETIREMENT VILLAGE	221 W	ADDRESS, CITY, STATE, ZIP COD DIVISION ST TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	assessment, dated 8 was moderately cog resident required a s with toileting, hygic resident had an indo A Care Plan, dated had an indwelling u for infection. An in catheter care as orde The October 2024 F indicated the reside - catheter care every - ensure catheter ba covered, and the tut floor A Physician's Order discontinued 8/27/2 250 mg (milligrams urinary tract infection During an interview ADON indicated th	Physician's Order Summary and had the following orders: whift g was below the waist, bing was not touching the grant of the control of the co			
F 0695 SS=D Bldg. 00	Suctioning Based on observation interview, the facility received the necessary	eostomy Care and on, record review and ty failed to ensure residents ary care and treatment related ment not changed as ordered rate of oxygen (O2)	F 0695	Step One: The oxygen issue identified in the survey were addressed immediately.	s 11/22/2024

11/19/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155667 B. WING 10/22/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 221 W DIVISION ST OAK GROVE CHRISTIAN RETIREMENT VILLAGE DEMOTTE, IN 46310 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE administered for 3 of 4 residents reviewed for reviewed for all residents using respiratory care. (Residents B, C, and D) oxygen and addressed immediately Findings include: Step Three: Nurses and CNAs 1. On 10/15/24 at 10:16 a.m., Resident B was were re-educated on the observed sitting in a wheelchair in her room. An importance of changing oxygen oxygen concentrator was next to the resident. supplies on a timely basis as well The water humidification bottle on the as the importance of accurate flow concentrator was dated, 10/6/24. The resident's rate settings. night stand drawer was open and a nebulizer treatment mask was observed, dated 10/6/24. Step Four: The Director of Nursing or her designee will audit Oxygen Record review for Resident B was completed on supplies and flow rates for all 10/16/24 at 3:02 p.m. Diagnoses included, but residents 5 times a week for the were not limited to, heart failure, respiratory first four weeks, then four times failure, and COPD (chronic obstructive pulmonary weekly for the next 4 weeks, then disease). twice weekly for the next 16 weeks. Results will be reported to The Quarterly Minimum Data Set (MDS) QAPI monthly. the QAPI team will assessment, dated 8/19/24, indicated the resident determine if the Plan requires was moderately cognitively impaired. The amendment or may be resident required oxygen therapy. discontinued. 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.

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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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	. BUILDING <u>00</u>		COMPLETED	
		155667	B. W	ING		10/22/2024	
		<u> </u>		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			DIVISION ST		
OVK CB	OVE CHRISTIAN E	RETIREMENT VILLAGE			TE, IN 46310		
OAN GIV	OVE CHINISTIAN IN	CHINEMENT VILLAGE		DLIVIOT	16, 11 40310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	changed.						
		0:37 a.m., Resident C was					
		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.						
	0.10/16/04 + 0.15						
	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						
	to an oxygen concentrator. The concentrator was set at a flow rate between 2 and 2.5 liters.						
	set at a now rate be	tween 2 and 2.3 liters.					
	Record review for l	Resident C was completed on					
		m. Diagnoses included, but					
	_	, cancer, hypertension,					
	depression, and CO						
	aspression, and co						
	The Annual Minim	um Data Set (MDS)					
		3/23/24, indicated the resident					
		gnitively impaired. The					
		substantial maximal assistance					
	with dressing and to	ransfers. The resident required					
	oxygen therapy.						
	A Care Plan, dated	6/2/23, indicated the resident					
	had a diagnosis of 0	COPD and used oxygen via					
	nasal cannula. An	intervention included for					
	oxygen as ordered.						
		POS indicated an order for					
	oxygen at 3 liters co	ontinuously.					
	Duning on internal	y on 10/16/24 at 2:15 the					
		v on 10/16/24 at 3:15 p.m., the					
		ne resident's oxygen was set at the correct flow rate.					
	3. Resident D was	observed in bed on 10/15/24 at					I

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155667	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/22/2024
	PROVIDER OR SUPPLIER	ETIREMENT VILLAGE	221 W	ADDRESS, CITY, STATE, ZIP COD DIVISION ST TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY	
	9:44 a.m. There was the foot of her bed, she only used at nig concentrator was la Resident D's record 1:44 p.m. Diagnose limited to, malignar pathological fractur neuromuscular dysf The Quarterly Mini assessment, dated 8 was cognitively inta During an interview 1 indicated the wate every week, and tha outdated. A policy titled, "Ox received as current indicated, "4 c. Ec prescribed flow rate tubing and mask/ca it becomes soiled or humidifier bottle wi facility policy" "5 nebulizer tubing and This citation relates 3.1-47(a)(6)	s an oxygen concentrator near which the resident indicated that. The water bottle in the beled 10/6/24. was reviewed on 10/17/24 at the included, but were not not neoplasm of kidney, UTI, the bone cancer, paraplegia, and function of bladder. mum Data Set (MDS) /27/24, indicated the resident fact. of on 10/15/24 at 11:00 a.m., LPN the bottle should be changed at the resident's bottle was rygen Administration" and from the facility on 10/22/24, quipment setting for the the sex" "5 b. Change oxygen nnula weekly and as needed if a contaminated. c. Change then empty, and weekly per the d. If applicable, change delivery devices weekly" sto Complaint IN00442131.	TAG		DATE
F 0758 SS=D Bldg. 00	Use Based on record rev	Psychotropic Meds/PRN view and interview, the facility	F 0758	Step One: Interventions and si	de 11/22/2024
		h resident's medication ged and monitored to promote		effects for the psychotropic medications could not be	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155667	B. W	ING		10/22/	/2024
NAME OF S	DROLUDED OF GUMPY TO		_	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIE	<			DIVISION ST		
OAK GR	OVE CHRISTIAN F	RETIREMENT VILLAGE	_		ГТЕ, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		dent's highest practicable			amended for the residents		
		nd psychosocial well-being			identified.		
	related to lack of no	-					
		prior to giving anti-anxiety			Step Two: The medication red	cords	
	medication and lack of monitoring for side effects of an antidepressant for 2 of 5 residents reviewed				of other residents receiving		
	_				psychotropic medications wer		
	_ ·	edications. (Residents 37 and			reviewed and also could not b	e	
	48)				amended.		
	Findings include:				Step Three: All nurses were		
					re-educated to the importance	of	
	1. Resident 37's record was reviewed on 10/18/24				documenting interventions		
	at 9:00 a.m. Diagnoses included, but were not				attempted prior to administeri	ng a	
	limited to, Alzheimer's dementia, depression and				psychotropic medication as w	ell	
	asthma.				as documentation of side effe	cts	
					following administration.		
		imum Data Set (MDS)					
	assessment, dated 7	7/19/24, indicated the resident			Step Four: The Director of Nu	rsing	
	had significant cog	nitive impairment and received			or her designee will audit the		
	anti-anxiety medica	ations.			Medication Administration Re	cord	
					for residents receiving		
	1	r, dated 6/24/24, indicated to			psychotropic medications onc		
		nti-anxiety medication), 0.25			weekly for the first four weeks		
		ery six hours as needed for as			then once every two weeks for		
	needed for anxiety.				next 4 weeks, then monthly fo		
					next 16 weeks. Results will be		
		r, dated 6/21/24, was for an			reported to QAPI monthly. the		
		ery shift: 1) Address physical			QAPI team will determine if th		
	, ,	vironment 3) Redirect			Plan requires amendment or i	may	
	thoughts 4) All of t	he above.			be discontinued.		
	The September and	October 2024 Medication					
	_	cord (MAR) indicated					
		en given on 9/3, 9/10, 9/21, 9/22					
	_	ras no documentation on the					
	MAR or in Progress Notes indicating any						
		al interventions had been					
		giving the medication.					
		, ,					
	During an interview	v on 10/21/24 at 11:10 a.m., the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155667	A. BUILDING B. WING	00	COMPLETED 10/22/2024	
		100001	_	ADDRESS CITY OF THE STREET	10/22/2027	
NAME OF P	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD DIVISION ST		
OAK GR	OVE CHRISTIAN R	ETIREMENT VILLAGE		TTE, IN 46310		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
TAG		(DON) provided medication	TAG		DATE	
	administration note	· · · · · · · · · · · · · · · · · · ·				
		al interventions had been				
	attempted on 9/3 and 10/13. There was no documentation for the remaining days.					
	2. Resident 48's red	cord was reviewed on 10/17/24				
		oses included, but were not				
		ied dementia, depression and				
	multiple sclerosis. The Significant Change MDS, dated 8/29/24, indicated the resident had moderate cognitive					
	impairment and rec	eived antidepressant				
	medications.					
	Δ Physician's Order	r, dated 8/13/24, indicated to				
		intidepressant), 100 mg daily				
	for depression.	1				
	•	r, dated 8/12/24, indicated to antidepressant), 150 mg daily				
	for depression.	anddepressant), 130 mg dany				
	231 30 p13551611.					
		dication Care Plan, dated				
		he resident was at risk for				
	adverse effects rela					
	medication that incl	ntions included, but were not				
		for any signs of adverse				
		pressant use such as dry				
	· ·	on, constipation, fatigue and				
	drowsiness.					
	There was no nhysi	cian's order or documentation				
		ord to indicate she was being				
	monitored for adver	_				
	During an interview	on 10/21/24 at 9:45 a.m., the				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155667	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/22/2024
	PROVIDER OR SUPPLIER	ETIREMENT VILLAGE	221 W	ADDRESS, CITY, STATE, ZIP COD DIVISION ST TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
F 0812 SS=F Bldg. 00	DON indicated antimedication side effects of the more resident's response to progress towards go adverse consequence the resident's medication of the more side effects of the more sident's response towards go adverse consequence the resident's medication of the more sident's medication of the more sident of the more	psychotic and antidepressant exts should be monitored every ld be a physician's order in oring. She indicated there was extropic Medication Policy", icated, "7. Residents who ugs shall also receive all interventions to facilitate inuation of the psychotropic also indicated, "8. Residents ic drugs will be observed for medication" and, "14. The to the medication(s), including the pals and presence/absence of es, shall be documented in	F 0812	Step One: The Dishwasher w serviced on 10/16/2024 Step Two: No other dishwash exist that could have a proble Step Three: All Dietary staff w re-educated on the need to monitor the temperatures for cycle of the wash and to reco that the temperature at the sta	as 10/22/2024 ers m. /ere each rd ant of
	at 9:00 a.m. with the	our was completed on 10/15/24 e Dietary Manager (DM). The shwasher was a high		washing dishes for each mea well as what to do when temperatures fall outside of th posted parameters.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETE			LETED	
		155667	B. W	ING		10/22/	/2024
		1		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			DIVISION ST		
OVK CB	OVE CHRISTIAN E	RETIREMENT VILLAGE			FTE, IN 46310		
OAN GN	OVE CHRISTIAN N	RETIREMENT VILLAGE		DEIVIO	11E, IN 40310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	temperature dish m	achine. A wash cycle was					
	observed and the w	ash temperature was 105		Step Four: The Dietary Manager or		jer or	
	degrees (Fahrenheit) and the rinse was 191				his designee will audit		
	-	ndicated the wash cycle should			documentation of dishwasher		
	be 180 degrees and he was unsure about the rinse cycle.				temps daily for the first 4 weel	κs,	
					then 5 times a week during we	eks	
					5-8, then three times a week		
	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				during weeks 9-26. Audit resu	lts	
					will be reported to QAPI montl	-	
					The QAPI team will determine	if	
					the plan should be amended of	r	
					discontinued.		
	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						
	T 1.	1 1 6 11					
	10/14- 178/185	s were recorded as follows:					
	10/14-1/8/183						
	Dinner temperature	es were recorded as follows:					
	10/2- 180/183	s were recorded as follows.					
	10/2-180/183						
	10/5- 181/187						
	10/6- 180/187						
	10/9- 129/134						
	10/10- 129/134						
	10/10-129/194						
	10/11-110/104						
	There were no addi	tional temperatures recorded					
		or dinner in October.					
	l contract, rancin						
	During an interview	v on 10/22/24 at 3:05 p.m., the					
		nanufacturer had come to the					
		to reset the dishwasher and					
					•		

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DENTIFICATION NUMBER A BULIDING DO DISPATION COMPLETED 10/22/2024	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	VIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
NAME OF PROVIDER OR SUPPLIER OKY) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LES IDENTIFYNO INFORMATION Temperatures were now in range. The policy, "Dishwasher Temperature", indicated, "	AND PLAN	OF CORRECTION				00		
ANAME OF PROVIDER OR ST.PPLER OAK GROVE CHRISTIAN RETIREMENT VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG THO PRICE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG The policy, "Dishwasher Temperatures, indicated, "Water 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 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 16 f 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 221 W DIVISION ST DEMOTITE, IN 48310 D PREFIX TAG DEMOTITE, IN 48310 CXS) COMPLETION TAG PREFIX TAG DEMOTICE, IN 48310 CXS) COMPLETION TAG PREFIX TAG DEMOTICE, IN 48310 CXS) COMPLETION TAG DEMOTICE, IN 48410 CROSS-RESERCES TO THE APPROPRIATE (X5) COMPLETION DATE TAG DEMOTICE, IN 48410 CXS1 TAG THE PROVISION ST EMONICATION TAG DEMOTICE, IN 48410 CXS1 TAG THE PROVISION ST EMONICATION TAG IN 4822 Step One: The name was added to the resident to the self-administration assessments were audited to verify the resident's name on assessments were audited to verify the res			155667	B. WI	NG		10/22/	/2024
### RECII ATORY OR LSC IDENTIFYING INFORMATION RECIII ATORY OR LSC IDENTIFYING INFORMATION				•	221 W	DIVISION ST		
PREFIX TAG CEACH DEFICENCY MUST BE PRECEDED BY FULL TAG COMPLETION DATE	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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 Bidg. 00 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 1016/24 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 The policy, "Dishwasher Temperature", indicated, "	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
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) 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 16 of 5 esidents reviewed for unnecessary medications. (Resident 23) 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, alted 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 8/24, indicated the resident could self-administrer Econazole nitrate The policy, "Dishwasher Temperature", indicated the resident and recorded and	TAG				TAG	DEFICIENCY)		DATE
powder (an antifungal medication) topically, twice daily to the groin and scrotum.	SS=D	The policy, "Dishw"Water temperature recorded prior to ear dishwasher has been cleaning purposes." 3.1-21(3) 483.20(f)(5), 483.7 Resident Records Based on record revialled to ensure clin accurately documenter resident's name on a administration assessive temperature for unnecessity. The record for Resi 10/16/24 at 2:46 p.r. were not limited to, (paralysis on one sistroke, aphasia (loss hypertension, and ristroke, aphasia (loss hypertension, and ristroke). The Quarterly Mini assessment, dated 8 had moderate cogniset up assistance for living. A Physician's Order resident could self-apowder (an antifung	asher Temperature", indicated, ares shall be measured and ach meal and/or after the n emptied or refilled for a solution of the number of the	F 08	342	to the self-administration of medication assessment for the resident identified. Step Two: All other self-administration assessment were audited to verify the resident's name was included. Step Three: All nursing staff were-educated to the importance including the resident's name assessment documents. Step Four: The Director of Nuror her designee will audit self administration assessments of weekly for the first four weeks then once every two weeks for next 4 weeks, then monthly for next 16 weeks. Results will be reported to QAPI monthly, the QAPI team will determine if the	e e e e e e e e e e e e e e e e e e e	11/22/2024

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DF6411

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155667	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/22/2024
	PROVIDER OR SUPPLIER	ETIREMENT VILLAGE	221	ET ADDRESS, CITY, STATE, ZIP COD W DIVISION ST IOTTE, IN 46310	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B. CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
F 0880 SS=D Bldg. 00	dated 8/2/24 and red Director of Nursing resident's name. During an interview ADON indicated th 23, but she accident the form instead of 3.1-50(a)(1)(2) 483.80(a)(1)(2)(4) Infection Prevention Based on observation failed to ensure infection place and implement and glove use during treatments observed Resident 20) Finding includes: During an observation care on 10/21/24 at Nurse was observed the right heel, right entered the room, we and water, and done removed the old dreleg, right ankle, and 10/19/24. She remonew gloves, without between glove use, to gauze and cleane threw away the gaus sprayed it with would still the same and cleane threw away the gaus sprayed it with would same and the same	(e)(f)	F 0880	Step One: the nurse identified re-educated. Step Two: No other issues we identified. Step Three: All nursing staff re-educated to the important proper infection control procedures. Step Four: The Director of Nor her designee will audit infecontrol practices during treatments once weekly for the first four weeks, then once etwo weeks for the next 4 weethen monthly for the next 16 weeks. Results will be report QAPI monthly, the QAPI tead determine if the Plan requires amendment or may be discontinued.	vere f were ce of dursing ection the very eks, ted to m will

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155667	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/22/2024
	ROVIDER OR SUPPLIER	ETIREMENT VILLAGE	221 W	ADDRESS, CITY, STATE, ZIP COD DIVISION ST TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	She did not perform gloves between cari opened a foam dress and removed a mark dressing, and contin without sanitizing h gloves. She applied dressing and placed She continued to ap ankle and right lower Tetracyte (topical aroil emulsion dressing over the topical aroil emulsion dressing dressing over the topical aroil emulsion dressing in place. Stremoved her gloves During an interview Wound Care Nurse to do hand hygiene new gloves between she should have chainto her pocket. During an interview Administrator indiction information to prove	r and cleaned the right heel. I hand hygiene or change ing for each wound. She sing, reached into her pocket ser, wrote the date on the foam mued to perform wound care er hands and changing honey wound gel to the foam it over the right heel wound. ply the dressings to the right er leg by putting drops of intibiotic) to the open areas, an ing, and then a calcium alginate p with rolled gauze to hold the ine dated the dressing, i, and washed her hands. Ton 10/21/24 at 11:26 a.m., the indicated she was supposed between glove use, put on in caring for each wound, and inged gloves after reaching Ton 10/22/24 at 12:57 PM, the ated she had no further ide. A corresponding policy etime, but was never received.			
R 0000					
Bldg. 00	Survey. This visit in State Licensure Sur	State Residential Licensure acluded a Recertification and evey. Der 15, 16, 17, 18, 21, and 22,	R 0000	This Plan of Correction shall s as this facility's credible allega of compliance. Completion and implementation of this plan is a confirmation of the statemental and facts set out in this survey	tion d not ts

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155667	B. W	NG	_	10/22/	/2024
NAME OF P	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			ADDRESS, CITY, STATE, ZIP COD		
	OVE OUDIOTIAN D	ETIDEMENT VIII A OF			DIVISION ST		
OAK GRO	OVE CHRISTIAN R	ETIREMENT VILLAGE		DEMO	ΓΤΕ, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					but rather an effort to continua	ally	
	Facility number: 01	0823			improve services to our reside	nts.	
					Please consider allowing		
	Residential Census:	29			submission of education and		
					audits as proof of compliance.		
		ntial Findings are cited in			Respectfully Submitted		
	accordance with 41	0 IAC 16.2-5.			Beth Ingram		
					VP of Operations		
	Quality review com	pleted on 10/29/24.			Oak Grove Christian Retirmer	ıt	
					Village		
R 0216	410 IAC 16.2-5-2(a)(1,4)(d)					
17 02 10	Evaluation - Nonc	,, ,, ,					
Bldg. 00	Evaluation - Nonc	omphance					
Blug. 00	Based on record rev	riew and interview, the facility	R0	216	Step One: The semiannual		11/22/2024
		ni-annual evaluations were	I K U	210	evaluation/Self Administration		11/22/2024
		7 records reviewed. (Residents			Assessment was completed for		
	1 -	y also failed to ensure self			the residents identified.	,,	
		ents were completed for 1 of 7			and residents identified.		
	records reviewed. (1	-			Step Two: All Assisted Living		
	`	,			resident records were audited	to	
	Findings include:				assure the semiannual evalua	ition/	
					Self Administration Assessme	nts	
	1. Resident 2's reco	ord was reviewed on 10/21/24 at			were completed. Evaluations	were	
	1:05 p.m. Diagnose	s included, but were not limited			updated for any that were four		
	to muscle weakness	and intravertebral disc			missing.		
	degeneration. The r	esident was admitted to the					
	facility on 1/31/23.				Step Three: Nursing Leadersh	ıip	
					and Assisted Living Nurses w	ere	
	The record lacked d	locumentation that a			re-educated to the importance	of	
	semi-annual evalua	tion had been completed.			completing the semiannual		
					evaluation/Self Administration		
					Assessment		
	_	ord was reviewed on 10/22/24 at					
	_	s were unavailable. The			Step Four: The Director of Nu	rsing	
	resident was admitte	ed to the facility on 12/15/22.			or her designee will audit		
					Semiannual evaluations/Self		
		locumentation that a			Administration Assessments of		
	semi-annual evalua	tion had been completed.			weekly for the first four weeks		
					then once every two weeks fo	r the	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155667	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/22/2024
	PROVIDER OR SUPPLIER	ETIREMENT VILLAGE	221 W	ADDRESS, CITY, STATE, ZIP COD DIVISION ST TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
ing	During an interview Medical Records in locate semi-annual and 3. 3. Resident 6 was con 10/22/24 at 2:30 Acetaminophen was resident indicated sl when she felt like sl know whenever she	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. 1. The icated she took the Acetaminophen lt like she needed it, and let the staff ever she took it. 1. The icated she was reviewed on 10/22/24 at 3:18 p.m., 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. 1. The icated she took the Acetaminophen lt like she needed it, and let the staff ever she took it. 1. The icated she was reviewed on 10:18 a.m. Diagnoses included, but		r the	
	were not limited to, heart failure, and cheart	respiratory failure, congestive ronic atrial fibrillation. nt Service Plan, updated e required a health care			
R 0217 Bldg. 00	410 IAC 16.2-5-2(Evaluation - Defici	, ,			
3. 33	interview, the facility Plans were complet urinary catheter mainsulin use for 4 of (Residents 2, 3, 4 and Findings include: 1. Resident 2's reconstruction.	on, record review and ty failed to ensure Service ed and/or updated related to magement, wound care and 7 resident records reviewed. ad 5) ord was reviewed on 10/21/24 at as included, but were not limited	R 0217	Step One: The Service Plans identified were updated to add the new needs. Step Two: All Resident's Serv Plans were reviewed to assur accuracy and updated if need Step Three: Nursing staff were re-educated to the importance updating each resident's service.	ice e ed. e of

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155667	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COMP	E SURVEY LETED 2/2024
	PROVIDER OR SUPPLIER	RETIREMENT VILLAGE	221 W	ADDRESS, CITY, STATE, ZIP DIVISION ST TTE, IN 46310	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
IAU	to muscle weakness degeneration. The reality on 1/31/23. A current Physician had a indwelling cait may be changed to dislodgement. A Progress Note, defacility nurse had so nurse who informed had been changed again. A Progress Note, defacility nurse had instructed to be changed again. The resident's Serve indicated the reside and she emptied it I not indicate a home the catheter or the form the catheter or the form the catheter of Nursing information related. 2. On 10/22/24 at 1 observed seated in twapped with a dreat a stool. He indicate leg and a home heat it. Resident 3's record 9:20 a.m. Diagnose resident was admitted.	s and intravertebral disc resident was admitted to the d's Order indicated the resident theter for urinary retention and for leakage, occlusion or leakage, occlusion or leakage with a home health d her the resident's catheter on 6/20/24 and was scheduled	IAG	plan as their needs of Step Four: The Direct or her designee will at Plans once weekly for weeks, then 4 every the next 4 weeks, the for the next 16 weeks be reported to QAPI QAPI team will detern Plan requires amend be discontinued.	ctor of Nursing audit 4 Service or the first four two weeks for en 4 monthly s. Results will monthly, the mine if the	DATE

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155667	r í	UILDING	instruction 00	(X3) DATE COMPL 10/22/	ETED
	PROVIDER OR SUPPLIEI OVE CHRISTIAN F	RETIREMENT VILLAGE		221 W [NDDRESS, CITY, STATE, ZIP COD DIVISION ST TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	described as a parti weeping of the leg	n area on his right calf al blister, some edema, and was also noted. The physician ea was treated with bacitracin dressing.					
	resident continued	dated 10/13/24, indicated the to receive treatment to right further progress notes after					
	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.						
	DON provided cop	v on 10/22/24, the Assistant ies of the Service Plan and but had no additional ole.					
	11:10 a.m. Diagnos limited to chronic k	ord was reviewed on 10/22/24 at ses included, but were not cidney disease and resident was admitted on					
	The record lacked a	a Service Plan for the resident.					
	Medical Records in locate a Service Pla reviewed on 10/22/ included, but were mellitus and cerebr						
	The October 2024	Physician Order Summary					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155667		(X2) MULTII A. BUILDII B. WING	PLE CONSTRUCTION NG 00	(X3) DATE COMPL 10/22	LETED		
NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 221 W DIVISION ST DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TA	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ECTION UULD BE PROPRIATE	(X5) COMPLETION DATE	
R 0246 Bldg. 00	Basaglar insulin 100 required twice daily The most recent Ser indicated the resider decision making, reto administer injection behavioral proble The Service Plan dimonitoring or insuling an interview Administrator indication formation to provide the administrator indication formation to provide the administrator indication formation to provide the alth Services - In the administrator indication formation to provide the alth Services - In the alth Services - In the alth Services - In the administrator indication for the administrator indication for the although the alth	d not address blood sugar n injections. on 10/22/24 at 2:14 p.m., the ated she had no further ide. e)(6) Deficiency iew and interview, the facility lifted medication aides athorization from a licensed rior to giving as needed for 2 of 7 records reviewed. r Resident 6 was completed on n. Diagnoses included, but respiratory failure, congestive ronic atrial fibrillation. Medication Administration cated QMA 1 administered a setron 4 mg (antinausea	R 0246	Step One: The QMA ide re-educated of the need nurse assess a resident permission for a PRN m to be administered. Step Two: The other res PRN medication records reviewed an no other er found. Step Three: QMAs and were re-educated to the importance of a nurse e the need for a PRN medication. Step Four: The Director or her designee will aud	I to have a a stand give hedication sident's so were rors were Nurses evaluating dication hering the	11/11/2024	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155667			UILDING	onstruction 00	(X3) DATE COMPL 10/22/	ETED		
NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 221 W DIVISION ST DEMOTTE, IN 46310					
PRE) ID EFIX AG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
		nurse or physician promedication. During an interview Director of Nursing medications were stapposed a progress note for administering them on the MAR. She was documentation the completed 2. Residual 10/22/24 at 9:58 a.r. not limited to, type cerebral infarction. The most recent Second indicated the reside decision making an professional to admiliquids. The October 2024 Findicated Tylenol 5 mouth every 8 hour ibuprofen 600 mg beneded for pain. The October 2024 Proceeding the control of the co	authorization from a licensed prior to administering the v on 10/22/24 at 3:55 p.m., the g (DON) indicated the PRN supposed to be documented in prior authorization before of the coresigned by an RN or LPN was unable to provide any prior authorization had been sent 5's record was reviewed on m. Diagnoses included, but were 2 diabetes mellitus and revice Plan, dated 9/19/24, and the was independent for daily direquired health care simister injections, pills, or Physician Order Summary 00 milligrams (mg) 2 tablets by sea as needed for analgesic and by mouth every 6 hours as Medication Administration for sated Tylenol was signed out QMA 1 on 10/11/24 at 1:45 4:55 p.m. Ibuprofen was signed by QMA 1 on 10/10/24 at 3:36 at 6:22 p.m.			medication administration reco once weekly for the first four weeks, then 5 records once even two weeks for the next 4 week 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 no be discontinued.	very s,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155667	A. BUILDING 00 COMPLETED B. WING 10/22/2024						
		133007							
NAME OF P	PROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP COD DIVISION ST				
OAK GR	OVE CHRISTIAN R	ETIREMENT VILLAGE		DEMO	TTE, IN 46310				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION		
TAG		LISC IDENTIFYING INFORMATION N Medication Policy,"		TAG			DATE		
		nedications are administered by							
		y authorized to do so through							
		nsure, in accordance with a							
	physician's order."								
R 0273	410 IAC 16.2-5-5.	1(f)							
D	Food and Nutrition	nal Services - Deficiency							
Bldg. 00			R 0	273	Step One: The Dishwasher wa	as	10/22/2024		
	Based on observation	on, record review and	TC 0.	213	serviced on 10/16/2024		10/22/2021		
	interview, the facili	ty failed to ensure a sanitary							
	kitchen related to di	shwasher temperatures not			Step Two: No other dishwash	ers			
		ed temperature and lack of			exist that could have a probler	n.			
	-	ring for a high temperature							
		had the potential to affect all			Step Three: All Dietary staff w	ere			
		ceived meals from the Main			re-educated on the need to				
	Kitchen.				monitor the temperatures for e				
	Finding includes:				cycle of the wash and to recort that the temperature at the sta				
	i manig meraaes.				washing dishes for each meal				
	The initial kitchen t	our was completed on 10/15/24			well as what to do when				
	at 9:00 a.m. with the	e Dietary Manager (DM). The			temperatures fall outside of th	е			
		ishwasher was a high			posted parameters.				
		achine. A wash cycle was							
		ash temperature was 105			Step Four: The Dietary Manag	jer or			
	- '	and the rinse was 191			his designee will audit				
		dicated the wash cycle should			documentation of dishwasher				
	cycle.	he was unsure about the rinse			temps daily for the first 4 weel then 5 times a week during we				
	cycle.				5-8, then three times a week	CKS			
	The Dish Machine	Гетрегаture Log for October			during weeks 9-26. Audit resu	lts			
		The log indicated, "High			will be reported to QAPI month				
		ne Wash 160 degrees, Rinse			The QAPI team will determine	-			
	180 degrees. Report	t any variations to the Food			the plan should be amended of				
	Service Supervisor	or Administrator."			discontinued.				
	Breakfast wash/rins	e temperatures were recorded							
	as follows:								
	10/2- 128/185								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155667		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 10/22/2024				LETED		
	PROVIDER OR SUPPLIE	R RETIREMENT VILLAGE	22	21 W C	DDRESS, CITY, STATE, ZIP COD DIVISION ST TE, IN 46310			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TA	ΑG	DEFICIENCY)		DATE	
	10/4- 130/187							
	10/9- 127/187							
	10/10-129/134							
	10/11- 138/187							
	10/14- 156/176							
	Lunch temperature 10/14- 178/185	es were recorded as follows:						
	10/2- 180/183	es were recorded as follows:						
	10/3- 181/185							
	10/5- 181/187							
	10/6- 180/187							
	10/9- 129/134 10/10- 129/134							
	10/10- 129/134							
		itional temperatures recorded n or dinner in October.						
	During an interview	w on 10/22/24 at 3:05 p.m., the						
	1	nanufacturer had come to the						
	facility on Tuesday	to reset the dishwasher and						
	temperatures were	now in range.						
	"Water temperate recorded prior to e	washer Temperature", indicated, ures shall be measured and ach meal and/or after the en emptied or refilled for						
R 0349	410 IAC 16.2-5-8 Clinical Records	, , , ,						
Bldg. 00	failed to ensure res and complete relate lack of a physician	view and interview, the facility ident records were accurate ed to lack of medical diagnoses, 's order for home health care an notification of blood	R 0349		Step One: The medical record those identified have been up to reflect the accurate medica diagnosis, home health orders well as physician notification of	dated I s as	11/22/2024	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU		(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE COMPL 10/22	LETED	
NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE			221 V	T ADDRESS, CITY, STATE, ZIP V DIVISION ST DTTE, IN 46310	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	_	de of parameters for 2 of 7 iewed. (Residents 3 and 5)		blood glucose outside prescribed parameter		
	observed seated in I wrapped with a dres a stool. He indicated leg and a home heat it. Resident 3's record 9:20 a.m. Diagnose resident was admitted A Progress Note, daresident had an open described as a partial weeping of the leg was notified, the area and covered with a A Progress Note, daresident continued to calf. There were no this date. The Electric Administration Reed discontinued on 10/10.	ated 10/13/24, indicated the to receive treatment to right further Progress Notes after ronic Treatment ord indicated treatments		Step Two: All Assiste residents medical recaudited to assure according to the iman accurate medical recepture well as the importance physician notification glucose is outside of parameters. Step Four: The Direct or her designee will a assisted living medication once weekly for the fit weeks, then 5 records two weeks for the next then 5 monthly for the weeks. Results will be QAPI monthly. the QA determine if the Plan amendment or may be discontinued.	sords were curacy. s were portance of records as e of when Blood prescribed tor of Nursing udit the 5 al records rst four s once every xt 4 weeks, e next 16 e reported to API team will requires	
	Resident diagnoses occasions and not p During an interview Director of Nursing	on 10/22/24, the Assistant provided copies of the Service of Orders, but had no additional				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155667		ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/22/	ETED	
NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE				221 W 🛭	DDRESS, CITY, STATE, ZIP COD DIVISION ST TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
TAU	2. Resident 5's reco 9:58 a.m. Diagnose	rd was reviewed on 10/22/24 at s included, but were not limited mellitus and cerebral infarction.		TAG			DAIL
	indicated the reside decision making, re	rvice Plan, dated 9/19/24, nt was independent for daily equired health care professional ions, pills, or liquids, and had ems.					
	indicated the reside Basaglar insulin 10 twice daily blood so	Physician Order Summary nt received 30 units of 0 unit/milliliter daily, required ugar monitoring, and required Physician if the blood sugar greater than 400.					
	Administration Rec blood sugars outsid required notificatio following dates and - 9/15/24 at 6:00 a.i	n., blood sugar: 64 n., blood sugar was blank					
	- 9/29/24 at 4:00 p.: - 10/2/24 at 6:00 a.: - 10/2/24 at 4:00 p.: - 10/9/24 at 6:00 a.: - 10/11/24 at 6:00 a - 10/19/24 at 6:00 a - 10/20/24 at 6:00 a	m., blood sugar was blank m., blood sugar: 51 m., blood sugar was blank					
		mentation to indicate the ied when the blood sugar was					
		on 10/22/24 at 2:14 p.m., the rated she had no further					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155667		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/22/2024		
NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE				221 W I	ADDRESS, CITY, STATE, ZIP COD DIVISION ST ITE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR information to provany documentation 410 IAC 16.2-5-8.			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg. 00	Clinical Records - Noncompliance		R 03	356	Step One: The emergency bir for the identified residents we updated. Step Two: All Assisted living residents emergency binders reviewed to verify all required information is present. Step Three: Nursing staff wer re-educated on the importance maintaining an accurate and date record in the emergency binder. Step Four: The Director of Nuror her designee will audit 5 emergency binders once wee for the first four weeks, then 5 once every two weeks for the 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 the discontinued.	were were ee ee of up to ursing kly next ne ee	11/22/2024

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