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	12/05/2024

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 Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the Investigation of Complaint IN00442131 completed on October 22, 2024. This visit included the PSR to the State Residential Licensure Survey completed on October 22, 2024. Complaint IN00442131 - Corrected Survey dates: December 4 and 5, 2024 Facility number: 010823 Provider number: 155667 AIM number: 200236630 Census Bed Type: SNF/NF: 44 SNF: 10 Residential: 30 Total: 84 Census Payor Type: Medicare: 10 Medicaid: 28 Other: 16 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/9/24.	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 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	F 0880	Step One: The nurse practitioner identified received a corrective	12/19/2024

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

Beth Ingram | Administrator | 01/13/2025

Any defiencystatement 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	in place and implemented related to hand hygiene and glove use during a wound treatment for 1 of 1 treatment observed. (Wound Care Nurse Practitioner, LPN 1, and Resident 61) Finding includes: During an observation of Resident 61's wound care on 12/5/24 at 9:34 a.m., the Wound Care Nurse Practitioner (NP) and LPN 1 were observed completing initial assessments and wound care to the resident's two wounds on the left lateral lower extremity. The Wound Care NP and LPN 1 both performed hand hygiene and donned a gown and gloves. LPN 1 removed the old dressings and then prepared gauze with wound cleanser to clean each of the wounds. The Wound Care NP cleaned the first wound, a diabetic ulcer to the left lateral lower extremity, with wound cleanser and gauze. She then asked LPN 1 for more gauze with wound cleanser and cleaned the second wound, a skin tear to the left lateral lower extremity. She did not perform hand hygiene and change her gloves before cleaning the second wound. The Wound Care NP and LPN 1 completed the wound treatments. During an interview on 12/5/24 at 10:04 a.m., the Wound Care NP indicated she should have performed hand hygiene and donned new gloves between cleansing each of the wounds. She was not expecting there to be two different wounds. That was her initial assessment of the resident and she was not informed that there was more than one wound on the left leg. During an interview on 12/5/24 at 11:01 a.m., the Director of Nursing indicated she had no further information to provide.		Plan of Cation and was re-educated to proper infection control procedures. Step Two: no other resident were affected by this practice. Step Three: All Nurses were re-educated on proper infection control procedures and hand hygiene. Step Four: The Director of Nursing or her designee will audit infection control practices of both facility staff as well as outside practitioners 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.	

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	A policy titled, "Hand Hygiene Policy," indicated "...2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table...Condition: before and after handling clean or soiled dressings... after handling items potentially contaminated with blood, body fluids, secretions, or secretions...when during resident care, moving from a contaminated body site to a clean body site..." A policy titled, "Clean Dressing Change," indicated "....3. Each wound will be treated individually...11. Perform hand hygiene and put on clean gloves. 12. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound...14. Perform hand hygiene and put on clean gloves." This deficiency was cited on October 22, 2024. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(b)			
R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on October 22, 2024. This visit included a PSR to the Recertification and State Licensure Survey and the Investigation of Complaint IN00442131 completed on October 22, 2024. Complaint IN00442131 - Corrected Survey dates: December 4 and 5, 2024 Facility number: 010823	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, 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	

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	Residential Census: 30 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 12/9/24.		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 a semi-annual evaluation was completed for 1 of 3 resident records reviewed. (Resident 3) Finding includes: Resident 3's record was reviewed on 12/4/24 at 9:20 a.m. There were no medical diagnoses available to review. The resident was admitted to the facility on 12/15/22. The record lacked documentation that a semi-annual evaluation had been completed. During an interview on 12/5/24 at 11:00 a.m., the Administrator and Director of Nursing were made aware the semi-annual evaluation was not available. There was no additional information provided. This deficiency was cited on 10/22/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	R 0216	Step One: The Semi-annual evaluations were completed for the residents identified. Step Two: All resident's Semi-annual evaluations were reviewed to assure accuracy. Step Three: Nursing staff were re-educated on the importance of updating the evaluation as needs change or at least semi-annually. 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 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. Additionally, the Administrator, DON, ADON and Social Services Director will meet weekly to review results of the audit and new admissions for the first two months.	12/23/2024

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R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure Service Plans were updated related to urinary catheter management and glucose monitoring for 2 of 3 resident records reviewed. (Residents 2 and 5) Findings include: 1. The record for Resident 2 was reviewed on 12/4/24 at 10:00 a.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. A Physician's Order, dated 1/31/23, indicated to maintain a catheter for urinary retention. The Service Plan, dated 11/21/24, indicated the resident needed assistance of one at times for toileting. The Service Plan did not indicate the resident had a catheter or who was to manage the catheter. During an interview on 12/5/24 at 9:05 a.m., the Director of Nursing (DON) indicated the facility staff was managing the resident's catheter. 2. The record for Resident 5 was reviewed on 12/5/24 8:50 a.m. Diagnoses included, but were not limited to, diabetes mellitus, heart failure and muscle weakness. The resident was admitted to the facility on 9/15/20. A Physician's Order, dated 10/22/24, indicated to check to resident's blood sugar twice daily.	R 0217	Step One: The Service Plans for the residents identified have been updated. Step Two: The Service Plans of all residents have been reviewed to assure accuracy. Step Three: Nursing staff have been re-educated to the importance of updating Service Plans as resident's needs change. Step Four: The Administrator, DON, ADON and Social Services Director will meet weekly to review results of the audit for the first two months. 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.	12/23/2024

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	The Service Plan, dated 11/21/24, indicated the resident needed no services related to Physical Health. The selection, "assist with routine blood glucose testing" was left unchecked. During an interview on 12/5/24 at 11:00 a.m., the DON and Administrator were made aware the Service Plan lacked catheter management for Resident 2 and lacked glucose monitoring for Resident 5. No additional information was provided. This deficiency was cited on 10/22/24. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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 a resident's record was accurate and complete related to lack of medical diagnoses for 1 of 3 records reviewed. (Resident 3) Finding includes: Resident 3's record was reviewed on 12/4/24 at 9:20 a.m. Diagnoses were unavailable. The resident was admitted to the facility on 12/15/22. During an interview on 12/4/24 at 1:05 p.m., the Director of Nursing was made aware there were no medical diagnoses present in the resident's record. No additional information was provided. This deficiency was cited on 10/22/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	R 0349	Step One: The medical record of the resident identified has been updated to reflect the accurate medical diagnosis. 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 Step Four: The Administrator, DON, ADON and Social Services Director will meet weekly to review results of the audit and new admissions for the first two months. The Director of Nursing or her designee will audit the 5 assisted living medical records	12/23/2024

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			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.	
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 12/4/24 at 1:15 p.m. The following information was missing: a. Resident 2 - missing hospital preference. b. Resident 3 - missing hospital preference. c. Resident 4 - missing hospital preference and emergency contact information. During an interview on 12/5/24 at 11:00 a.m., the Administrator indicated she was not aware the above information was needed, but would get it corrected. This deficiency was cited on 10/22/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	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 Administrator, DON, ADON and Social Services Director will meet weekly to review results of the audit and new admissions for the first two months. 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	12/23/2024

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			reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may be discontinued.	