PRINTED: 01/21/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155667	B. WING	12/05/2024		
			CTDEET	ADDRESS CITY STATE ZIP COP		
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
OAK OB	OVE CHDISTIAN F	DETIDEMENT VILLAGE		DIVISION ST TTE, IN 46310		
UAN GR	OVE UNKISTIANT	RETIREMENT VILLAGE	DEMO	1 1 E, IIN 403 IU		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0000						
Bldg. 00						
		a Post Survey Revisit (PSR) to	F 0000	This Plan of Correction shall		
		and State Licensure Survey		as this facility's credible alleg		
	_	on of Complaint IN00442131		of compliance. Completion ar		
	_	ober 22, 2024. This visit		implementation of this plan is	not	
		to the State Residential		a confirmation of the stateme		
	Licensure Survey	completed on October 22, 2024.		and facts set out in this surve	- I	
				but rather an effort to continu	-	
	Complaint IN0044	2131 - Corrected		improve services to our residence	ents.	
				Please consider allowing		
	Survey dates: Dece	ember 4 and 5, 2024		submission of education and		
				audits as proof of compliance		
	Facility number: 0			Respectfully Submitted		
	Provider number:			Beth Ingram		
	AIM number: 2002	236630		VP of Operations		
				Oak Grove Christian Retirme	nt	
	Census Bed Type:			Village		
	SNF/NF: 44					
	SNF: 10					
	Residential: 30					
	Total: 84					
	Census Payor Type	e:				
	Medicare: 10					
	Medicaid: 28					
	Other: 16					
	Total: 54					
	TEI 1 C	G + G+ + F' 1' '+ 1'				
		reflect State Findings cited in				
	accordance with 4	IU IAC 10.2-3.1.				
	0 17	1 4 1 12/0/24				
	Quanty review cor	mpleted on 12/9/24.				
F 0880	483 80(5)(4)(2)(4	\(a\(f\)				
SS=D	483.80(a)(1)(2)(4 Infection Prevent					
Bldg. 00	intection Frevent	IOII & COIIIIOI				
Diag. 00	Based on observat	ion and interview, the facility	F 0880	Step One: The nurse practition	ner 12/19/2024	
		Pection control guidelines were	L 0880	identified received a corrective		
	laneu to ensure ini	ection control guidelines were		identified received a correctiv	E	
LADORATO	N DIDECTORIC OF PRO	NAMED (CLIDITIES DESDECENTA TO TOO	ELCNIA TUDE	TITLE	(VC) DATE	
LABOKATO	CI DIKECTOR'S OK PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	SIGNA I UKE	TITLE	(X6) DATE	
Beth Ingram			Administ	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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DF6412 Facility ID: 010823 If continuation sheet

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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	JILDING	00	COMPL	LETED
		155667	B. WING 12/05/2024			/2024	
			<u> </u>	STDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			DIVISION ST		
	OVE CHRISTIAN D	ETIREMENT VILLAGE			TTE, IN 46310		
OAN GR	OVE CHINISHAIN R	LINEWENT VILLAGE		DEMO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRE		N (X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION			DEFICIENCY)		DATE
		nented related to hand hygiene			Plan of Cation and was		
	_	g a wound treatment for 1 of 1			re-educated to proper infection	n	
		(Wound Care Nurse			control procedures.		
	Practitioner, LPN 1	, and Resident 61)			Step Two: no other resident w	ere	
					affected by this practice.		
	Finding includes:				Step Three: All Nurses were		
					re-educated on proper infection	n	
	-	ion of Resident 61's wound			control procedures and hand		
		2:34 a.m., the Wound Care			hygiene.		
		(NP) and LPN 1 were observed			Step Four: The Director of Nu	-	
		ssessments and wound care to			or her designee will audit infe		
		younds on the left lateral lower			control practices of both facilit	у	
		and Care NP and LPN 1 both			staff as well as outside		
		giene and donned a gown and			practitioners during treatments	3	
	-	oved the old dressings and then			once weekly for the first four		
		h wound cleanser to clean each			weeks, then once every two		
		Wound Care NP cleaned the			weeks for the next 4 weeks, the		
	· ·	etic ulcer to the left lateral lower			monthly for the next 16 weeks		
		and cleanser and gauze. She			Results will be reported to QA	Pl	
		or more gauze with wound			monthly. the QAPI team will		
		d the second wound, a skin			determine if the Plan requires		
		al lower extremity. She did not			amendment or may be		
		ene and change her gloves			discontinued.		
	_	second wound. The Wound					
		completed the wound					
	treatments.						
	Duning on intermi	v on 12/5/24 at 10:04 a.m., the					
	_	dicated she should have					
		giene and donned new gloves					
		<del>-</del>					
	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						
	man one wound on	the left leg.					
	During an interview on 12/5/24 at 11:01 a.m., the						
		; indicated she had no further					
	information to prov						
	information to provide.						

FORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155667		A. BU	(x2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/05/2024		
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	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	
	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 tableCondition: before and after handling clean or soiled dressings after handling items potentially contaminated with blood, body fluids, secretions, or secretionswhen 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 individually11. 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 wound14. 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.							
R 0000							1	
Bldg. 00	the State Residentia on October 22, 2024 the Recertification a	2131 - Corrected mber 4 and 5, 2024	R 00	000	This Plan of Correction shall so as this facility's credible allega of compliance. Completion and implementation of this plan is raconfirmation of the statemen and facts set out in this survey but rather an effort to continua improve services to our reside Please consider allowing submission of education and audits as proof of compliance. Respectfully Submitted	tion d not ts , lly nts.		

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155667	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/05/2024		
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	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		
R 0216 Bldg. 00	Quality review com 410 IAC 16.2-5-2( Evaluation - Nonco	otial Findings are cited in DIAC 16.2-5.  pleted on 12/9/24.  c)(1-4)(d)  compliance	R 0216	Beth Ingram VP of Operations Oak Grove Christian Retirmer Village  Step One: The Semi-annual	12/23/2024		
	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.		K 0210	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			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155667		A. BUILDING B. WING	COMPLETED 12/05/2024		
	PROVIDER OR SUPPLIER OVE CHRISTIAN R	ETIREMENT VILLAGE	221 W	ADDRESS, CITY, STATE, ZIP COD DIVISION ST TTE, IN 46310	
(X4) ID PREFIX TAG R 0217	(EACH DEFICIENG REGULATORY OR 410 IAC 16.2-5-2(	* * *	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	failed to ensure Service related to urinary car glucose monitoring reviewed. (Resident Findings include:  1. The record for Resident 12/4/24 at 10:00 a.m were not limited to, intravertebral disc dadmitted to the facil A Physician's Order maintain a catheter:  The Service Plan, daresident needed assist toileting. The Service resident had a catheteatheter.  During an interviewed Director of Nursing staff was managing 12. The record for Resident had a catheter.  Limited to, diabetes in muscle weakness. The facility on 9/15/24 A Physician's Order 15/15/24 A Physici	riew and interview, the facility vice Plans were updated theter management and for 2 of 3 resident records is 2 and 5)  resident 2 was reviewed on in. Diagnoses included, but muscle weakness and egeneration. The resident was lity on 1/31/23.  red, dated 1/31/23, indicated to for urinary retention.  rated 11/21/24, indicated the stance of one at times for the Plan did not indicate the ter or who was to manage the role of the facility the resident's catheter.  resident 5 was reviewed on this plant is catheter.  resident 5 was reviewed on this plant is catheter.	R 0217	Step One: The Service Plans the residents identified have updated. Step Two: The Service Plans residents have been reviewer assure accuracy. Step Three: Nursing staff have been re-educated to the importance of updating Service Plans as resident's needs chooking Step Four: The Administrate DON, ADON and Social Service Director will meet weekly to results of the audit for the first months. The Director of Nursher designee will audit 4 Service Plans once weekly for the first weeks, then 4 every two weeks, then 4 every two weeks, then 4 weeks, then 4 more for the next 16 weeks. Result be reported to QAPI monthly QAPI team will determine if the Plan requires amendment or be discontinued.	been s of all ed to  ve  ice nange. or, vices review st two sing or vice st four eks for nthly lts will v. the

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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 12/05/2024		
	PROVIDER OR SUPPLIER	ETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP COD  221 W DIVISION ST  DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
R 0349 Bldg. 00	resident needed not Health. The selection glucose testing" was buring an interview DON and Administ Service Plan lacked Resident 2 and lack Resident 5. No additionate provided.  This deficiency was failed to implement to prevent recurrence 410 IAC 16.2-5-8. Clinical Records - Based on record revialed to ensure a reand complete relate for 1 of 3 records resident 3's record 9:20 a.m. Diagnose resident was admitted During an interview Director of Nursing medical diagnoses provided to the selection of the selection	on 12/5/24 at 11:00 a.m., the rator were made aware the catheter management for ed glucose monitoring for tional information was  a cited on 10/22/24. The facility a systemic plan of correction e.e.  1(a)(1-4)  Noncompliance  riew and interview, the facility sident's record was accurate d to lack of medical diagnoses eviewed. (Resident 3)  was reviewed on 12/4/24 at s were unavailable. The ed to the facility on 12/15/22.  If on 12/4/24 at 1:05 p.m., the was made aware there were no present in the resident's record. In the resident's record. In the resident's record. In the resident's record. In a systemic plan of correction	R 034	9	Step One: The medical record the resident identified has bee 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 an accurate medical records  Step Four: The Administrator, DON, ADON and Social Service Director will meet weekly to revesults of the audit and new admissions for the first two months. The Director of Nursin her designee will audit the 5 assisted living medical records	e of ces view	12/23/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155667		l í	ILDING	nstruction 00	(X3) DATE COMPL 12/05/	ETED		
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	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
					once weekly for the first four weeks, then 5 records once etwo weeks for the next 4 week then 5 monthly for the next 16 weeks. Results will be reported QAPI monthly, the QAPI team determine if the Plan requires amendment or may be discontinued.	ks, S ed to n will		
R 0356 Bldg, 00	410 IAC 16.2-5-8. Clinical Records -	,						
Bldg. 00	failed to ensure the contained all the new residents reviewed.  Findings include:  The resident Emerg 12/4/24 at 1:15 p.m. missing:  a. Resident 2 - miss  b. Resident 3 - miss  c. Resident 4 - miss emergency contact in the content of the corrected.  This deficiency was	on 12/5/24 at 11:00 a.m., the ated she was not aware the was needed, but would get it cited on 10/22/24. The facility a systemic plan of correction	R 03	56	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 Administrator, DON, ADON and Social Serv Director will meet weekly to re results of the audit and new admissions for the first two months. The Director of Nursi her designee will audit 5 emergency binders once week 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	were  e e of up to  ices eview  ng or  kly  next	12/23/2024	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID 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 COMPLETED 00 155667 B. WING 12/05/2024 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 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE reported to QAPI monthly. the QAPI team will determine if the Plan requires amendment or may

be discontinued.

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