| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155667 | A. BUILDING 00<br>B. WING | 05/07/2025 |

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| OAK GROVE CHRISTIAN RETIREMENT VILLAGE | 221 W DIVISION ST<br>DEMOTTE, IN 46310 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00455274.<br><br>Complaint IN00455274 - Federal/state deficiencies related to the allegations are cited at F684 and F689.<br><br>Survey dates: May 6 & 7, 2025<br><br>Facility number: 010823<br>Provider number: 155667<br>AIM number: 200236630<br><br>Census Bed Type:<br>SNF/NF: 43<br>SNF: 10<br>Residential: 33<br>Total: 86<br><br>Census Payor Type:<br>Medicare: 10<br>Medicaid: 29<br>Other: 14<br>Total: 53<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 5/12/25. | F 0000 | Please accept this plan of correction as this facility's credible allegation of compliance. Preparation and implementation of this plan of correction does not indicate agreement with the findings set out in the survey, but rather this facility's commitment to continuous quality improvement. We respectfully request that the submission of education and attendance, as well as audits be used to verify compliance in a desk review.<br><br>Respectfully Submitted<br>Beth Ingram<br>Administrator | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br><br>Based on record review and interview, the facility failed to ensure a resident who received new diagnoses of a fractured right tibia and multiple fractured ribs from a facility incident was assessed | F 0684 | Step One: The nurses who should have completed the assessments for this resident will be re-educated to the importance of | 05/29/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Beth Ingram | Administrator | 05/24/2025 |

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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| | thoroughly and frequently upon returning from the Emergency Room for 1 of 3 residents reviewed for quality of care. (Resident B)<br><br>Finding includes:<br><br>Resident B's record was reviewed on 5/6/25 at 10:26 a.m. The diagnoses included, but were not limited to, a spiral fracture of the right tibia, peripheral vascular disease, history of traumatic brain injury, and cognitive deficit.<br><br>Cross reference F689.<br><br>A Nurse's Progress Note, dated 3/10/25 at 10:29 p.m., indicated the resident returned to the facility per ambulance. She was assisted to bed by two staff. There was an immobilizer on the right lower leg. She complained of pain to the area.<br><br>A Nurse's Progress Note, dated 3/11/25 at 1:37 a.m., indicated the immobilizer on the right leg was in place. There was no assessment of the right leg or the status of the resident.<br><br>There were no assessments completed by the nurses on 3/12/25.<br><br>A Nurse Practitioner (NP) Progress Note, dated 3/12/25 at 9:51, indicated an immobilizer had been placed on the right lower leg due to a tibia fracture. Tylenol was not effective for the pain and an order for Norco (narcotic pain medication) was given and effective. She appears to be in distress and pain. She was grimacing anytime the leg was moved. Pain medication was increased to twice a day.<br><br>A Nurse's Progress Note, dated 3/13/25 at 10:52 a.m., indicated there was edema of the bilateral | | thorough assessments upon return from a hospital or significant injury.<br>Step Two: An audit of residents with significant injury was completed to identify others affected by the deficient practice and none were identified. Any nurses who did not complete the required assessments were re-educated.<br>Step Three: Nursing staff will be re-educated on acute condition change as well as the need to monitor and document the resident's progress and response to treatment.<br>Step Four: The Director of Nursing or her designee will audit the records of residents with significant injury during morning clinical start up to assure proper assessment is completed each shift for at least 72 hours following the occurrence. Audits will be completed for all significant injuries five days weekly for 3 months, then all significant injuries 3 times a week for the next 3 months then twice weekly for three months. Audit results will be reported monthly to QAPI. The QAPI team will determine if audits should be amended or discontinued. | |

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| | lower extremities. No further assessment of the status of the leg or fractured ribs were documented.<br><br>There were no further assessments completed on the right leg status and fractured ribs.<br><br>During an interview on 5/7/25 at 9:46 a.m., the Director of Nursing indicated the nurses' were to complete follow up assessments. She indicated there were no further assessments found.<br><br>An acute condition change policy, dated 1/23/24 and received from the Director of Nursing as current, indicated the staff were to monitor and document the resident's progress and responses to treatment.<br><br>This citation relates to Complaint IN00455274.<br><br>3.1-37 | | | |
| F 0689 SS=G Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>Based on observation, record review, and interview, the facility failed to ensure a resident received proper assistance to prevent accidents, related to a CNA (Agency CNA 1) transferring a dependent resident (Resident B) from the bed to a chair without following the plan of care, causing pain and fractures to the resident's right leg and left ribs. The facility also failed to ensure Resident D, who was a high risk for falls and had a history of falls, was adequately supervised to prevent a fall which resulted in a head laceration requiring staples for healing for 2 of 3 residents reviewed for accidents/supervision.<br><br>Findings include: | F 0689 | Step One: The agency staff attending resident B was placed on "do not return" and his agency was informed of his failure to follow the resident's plan of care. The staff member attending resident D was re-educated on the importance of not leaving a resident at high risk of falls alone, even for a short moment.<br>Step Two: Nursing staff were re-educated of the importance of following the CNA assignment sheets/care cards to provide resident care accurately. | 05/29/2025 |

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| | 1. During an observation on 5/6/25 at 9:25 a.m., Resident B was sitting in a high back reclining chair. A mechanical lift pad was underneath the resident. She indicated the staff used a mechanical lift to transfer her. There was an immobilizer on her right lower leg.<br><br>Resident B's record was reviewed on 5/6/25 at 10:26 a.m. The diagnoses included, but were not limited to, a spiral fracture of the right tibia, peripheral vascular disease, history of traumatic brain injury, and cognitive deficit.<br><br>A Care Plan, dated 11/1/23 and reviewed on 1/13/25, indicated assistance was required for activities of daily living. The interventions included a mechanical lift was to be used for all transfers with the assistance of two staff members.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 2/8/25, indicated the resident had moderate cognitive impairment, had no behaviors, no impairment of movement of the upper and lower extremities, was dependent for all activities of daily living (ADL's) except eating, had no falls, and received an antiplatelet medication.<br><br>A Physical Therapy Evaluation and Plan of Treatment, dated 2/28/25, indicated the resident was dependent for bed mobility and transfers, had decreased balance, and a mechanical lift and a high back wheelchair with elevating legs were to be utilized for the resident.<br><br>The CNA Care Card, dated 3/7/25, indicated the resident required a mechanical lift for transfers and was dependent for care. The night shift staff were to assist the resident out of bed in the | | Following assignment sheets/care cards has been added to the Agency staff orientation sheet that must be completed prior to working the floor. Agency staff who are already orientated will be re-educated to the use of assignment sheets/care cards.<br>Step Three: Nursing staff were re-educated of the importance of following the CNA assignment sheets/care cards to provide resident care accurately.<br>Following assignment sheets/care cards has been added to the Agency staff orientation sheet that must be completed prior to working the floor. Agency staff who are already orientated will be re-educated to the use of assignment sheets/care cards.<br>Step Four: The DON or her designee will audit use of CNA assignment sheets on all shifts. 20 residents will be audited weekly for the first four weeks, then 15 weekly for weeks 5-8, then 10 residents audited weekly for weeks 9-12, then 5 residents audited weekly weeks 13-16 then one resident weekly, weeks 17-24. Results of the audit will be reported to QAPI monthly. the QAPI team will make recommendations to the plan as needed including the need to discontinue audits. | |

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| | morning.<br><br>A Nurse's Progress Note, dated 3/10/25 at 7:20 a.m., indicated the day shift CNA (CNA 3) reported to the nurse that there was bruising to the resident's right shin. The resident denied pain and winced when touched. The night shift CNA (Agency CNA 1) indicated the resident's legs were hanging out of the bed when he entered the room that morning. Pain medication was administered as ordered and the Nurse Practitioner (NP) was notified. Orders were received for a STAT x-ray of the right shin and the resident's family was notified.<br><br>The NP Progress Note, dated 3/10/25, indicated there were complaints of pain and swelling in the right lower extremity. There was localized redness, swelling, and pain to her right tibia a couple inches below her knee. There was pain with palpation. There was no obvious deformity but a large amount of swelling. The resident was grimacing and appeared to be in distress. There was no respiratory distress, and the breath sounds were clear. After the visit the x-ray result was received and indicated a right proximal tibia fracture, she was transferred to the Emergency Room for further evaluation.<br><br>A mobile x-ray report, dated 3/10/25 at 2:36 p.m., indicated there was an acute appearing proximal right tibia fracture.<br><br>The Emergency Room Physician's Progress Note, dated 3/10/25 at at 1:53 p.m., indicated right lower leg injury, normal breath sounds and no respiratory distress. She had intact distal pulses, no edema, tenderness, or major deformities of the extremities. The hospital x-ray of the right tibia and fibula indicated a nondisplaced spiral fracture | | | |

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| | of the proximal tibia. There was no abnormal soft tissue calcification, and bone mineralization was normal. The chest x-ray indicated there were multiple left lower rib fractures. The family opted for conservative treatment. A knee immobilizer was applied, and the resident was transferred back to the facility.<br><br>A Hospital Emergency Room Note, dated 3/10/25 at 7:00 p.m., indicated the resident had no acute distress and was transferred back to the facility.<br><br>A Nurse's Progress Note, dated 3/10/25 at 10:29 p.m., indicated the resident returned to the facility per ambulance. She was assisted to bed by two people. There was an immobilizer on the right lower leg. She complained of pain to the area.<br><br>An NP Progress Note, dated 3/12/25 at 9:51 a.m., indicated an immobilizer had been placed on the right lower leg due to a tibia fracture. Tylenol was not effective for the pain and an order for Norco (narcotic pain medication) was given and effective. She appeared to be in distress and pain. She was grimacing any time the leg was moved. Pain medication was increased to twice a day.<br><br>A Physician's Order, dated 3/12/25, indicated Norco 5 - 325 milligrams, give one tablet twice a day.<br><br>An Indiana Department of Health (IDOH) reported incident, dated 3/10/25 with follow up on 3/24/25, indicated on 3/10/25 at 6:30 a.m., a CNA observed a large bruise on the resident's left shin (sic) (right shin) and notified the nurse. An x-ray was obtained and an acute proximal tibia fracture was found on the left (sic) leg. The resident was then transferred to the Hospital Emergency Room for a further evaluation. | | | |

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| | The investigation of the incident included the following:<br><br>A handwritten statement by LPN 4, dated and signed on 3/10/25 and no time documented, indicated CNA 3 asked her to assess the resident's swollen area on the right leg. There was a 2 centimeter (cm) by 2 cm raised hematoma on the right shin. The resident was asked what happened and she stated she was "skipping and fell". She denied pain. She drew her leg back with light palpitation. An as needed Tylenol was administered. Agency CNA 1 was interviewed. He indicated when he entered the room, the resident's legs were hanging out of the bed. LPN 4 clarified the statement and asked if the resident had been falling out of the bed and Agency CNA 1 stated, "no". He indicated he dressed her and transferred her into the wheelchair. The NP was notified, and an x-ray was ordered. A skin assessment was completed, and no other bruises or injuries were observed.<br><br>A handwritten statement by CNA 3, dated and signed on 3/10/25 and no time documented, indicated she came into work at 6:00 a.m. She was receiving a walking rounds report from Agency CNA 1. Resident B was sitting in her room in a wheelchair with the mechanical lift pad positioned under the resident. She checked the positioning of the resident and made sure her feet were on the foot pedals. When she started to adjust the right leg, she observed a large swollen bruise under the right knee and the resident called out in pain. The nurse was immediately notified.<br><br>A text message from the Administrator to Agency CNA 1, dated 3/10/25 at 12:27 p.m., asked the CNA for a written statement. Agency CNA 1 responded | | | |

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| | on 3/10/25 at 9:21 p.m. and indicated a statement would be emailed.<br><br>An e-mailed statement from Agency CNA 1, dated 3/11/25 at 1:09 a.m., indicated the resident had been obvert (sic) with her left and right legs hanging off the left side of the bed. The legs were lifted back onto the bed and she was placed in the wheelchair. The day shift CNA came into the room and noticed the resident grimacing with pain when she attempted to place her legs on the leg rests, and she alerted the nurse.<br><br>An e-mailed statement from Agency CNA 1, dated 3/11/25 at 11:47 a.m., indicated he had not used the mechanical lift to transfer the resident. He had placed an arm under both her legs and the other arm under her back and lifted her into the wheelchair. He had sent a picture with e-mail that had a man cradling a woman in his arms, with one arm around her back and one arm supporting the knees. The typed statement under the picture was, "Like this into her wheelchair."<br><br>The Facility Investigation of the incident, dated 3/10/25, indicated several staff who had worked with the resident one to two days prior to the incident had been interviewed and no injury had been observed. The conclusion of the investigation indicated the injury "likely" occurred when the resident was transferred from the bed to the chair without the use of the mechanical lift.<br><br>Agency CNA 1 had signed an orientation acknowledgement for the facility on 11/26/24.<br><br>During an interview on 5/7/25 at 8:30 a.m., the Administrator indicated the orientation of the residents and their care for the agency staff was | | | |

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| | completed by the nursing staff when the Agency Staff were working. They received report from the nurses and the CNAs, and they were given the CNA Care Card. Agency CNA 1 knew the mechanical lift was to be utilized for the resident's transfer, he placed the lift pad on the wheelchair before he lifted the resident into the wheelchair. She indicated that he had worked at the facility numerous times.<br><br>A facility mechanical lift policy, dated 6/2024 and received from the Administrator as current, indicated the interdisciplinary team evaluated and assessed each resident's individual mobility needs and the mechanical lift would be utilized based on the resident's needs. Staff were expected to maintain compliance with safe handling/transfer practices. Resident transfers were to be performed according to the individual plan of care.<br><br>2. During an observation on 5/7/25 at 2:12 p.m., Resident D was sitting outside in a wheelchair during an activity. She was smiling and had no signs or symptoms of pain. There was a bruise and five staples located on the left front forehead.<br><br>Resident D's record was reviewed on 5/7/25 at 2:07 p.m. The diagnoses included, but were not limited to, stroke and osteoporosis.<br><br>A Care Plan, dated 3/11/25, indicated there was a risk for falls. The intervention, dated 11/26/24, indicated the resident would be assisted to the bathroom.<br><br>A Fall Assessment, dated 1/11/25, indicated the resident was disoriented to person, place, and time, had a fall in the past three months, was chair bound, was unable to perform the gait balancing | | | |

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| | assessment, received medications that could cause falls, and was high risk for falls.<br><br>A Quarterly MDS assessment, dated 2/28/25, indicated a severely impaired cognition status, no behaviors, no impairment of the upper and lower extremities, required moderate assistance for toilet transfers and hygiene and maximum assistance for transfers. She required a wheelchair for mobility.<br><br>An undated CNA Care Card indicated the resident was a one person assist with the gait belt, a wheelchair was used, and in capital red letters it stated the resident was a fall risk.<br><br>A Nurse's Progress Note, dated 4/28/25 at 6:28 a.m., indicated the staff had alerted the nurse at approximately 5:10 a.m. that the resident had fallen. The resident was observed lying on the bathroom floor on her right side. There was blood on the floor and the CNA was holding pressure to the resident's head. There was a laceration on the left side of the resident's head. The Emergency Medical System was notified for the resident to be transferred to the hospital.<br><br>A Written Statement, signed and dated by CNA 2 on 4/28/25 at 5:15 a.m., indicated the resident was in the bathroom on the toilet. The CNA, "turned her back for a couple of seconds" to obtain a pair of socks and heard the resident fall. The nurse was notified, and pressure was applied to the wound until the medics arrived.<br><br>A Nurse's Progress Note, dated 4/28/25 at 11 a.m., indicated the resident returned from the hospital. The forehead laceration measured 3 cm by 0.1 cm and there were five staples placed that closed the wound. The resident was placed on every 15-minute checks. | | | |

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| | A Post Fall Assessment, dated 4/28/25 at 1:30 p.m., indicated the fall had not been witnessed. The fall occurred in the bathroom and the resident attempted to self-toilet at the time of the fall. The resident stood up from the toilet and fell.<br><br>An Interdisciplinary Team Note, dated 4/28/25, indicated the CNA had left the resident alone in the bathroom while she retrieved her clothing for the day and the resident fell.<br><br>An IDOH reported incident, dated 4/28/25, indicated on 4/28/25 at 5:10 a.m., CNA 2 had alerted the nurse the resident had fallen in the bathroom. The resident was found lying on the bathroom floor on her right side. CNA 2 was holding pressure to the left side of the resident's head due to a laceration. CNA 2 had indicated she turned around to retrieve a pair of socks, and the resident attempted to perform self-toilet hygiene and fell. The resident was immediately transferred to the Emergency Room. The interventions that were put into place included the resident would not be left unattended while in the bathroom and clothing needed was to be placed in reach while care was provided.<br><br>During an interview on 5/7/25 at 2:30 p.m., the Director of Nursing (DON) indicated CNA 2 was not in the bathroom at the time of the fall. Residents who were at high risk for falls were not to be left alone in the bathroom.<br><br>During an interview on 5/7/25 at 2:35 p.m., the Administrator indicated CNA 2 was in the bathroom at the time of the fall. Her written statement indicated she had just turned her back to the resident for a few seconds. | | | |

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| | 155667 | A. BUILDING 00<br>B. WING | 05/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| OAK GROVE CHRISTIAN RETIREMENT VILLAGE | 221 W DIVISION ST<br>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 |
|---|---|---|---|---|
| | During an interview on 5/7/25 at 2:37 p.m., CNA 2 indicated the resident had never tried to stand on her own before. The resident was on the toilet. She had forgotten to get the resident's socks when she assisted her into the bathroom. She went out of the bathroom to the dresser to get the socks. The resident was always in her sight, until she turned for a second to get the socks and then she heard the resident fall.<br><br>This citation relates to Complaint IN00455274.<br><br>3.1-45(a)(2) | | | |