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	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OAK GROVE CHRISTIAN RETIREMENT VILLAGE	221 W DIVISION ST DEMOTTE, IN 46310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and the Investigation of Nursing Home Complaint IN00386370. Complaint IN00386370 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: September 7, 8, 9, 12, 13, and 14, 2022. Facility number: 010823 Provider number: 155667 AIM number: 200236630 Census Bed Type: SNF/NF: 29 SNF: 14 Residential: 31 Total: 74 Census Payor Type: Medicare: 10 Medicaid: 21 Other: 12 Total: 43 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/16/22.	F 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Oak Grove Christian Retirement Village desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on October 14, 2022. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of			

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

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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	abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure a complete and thorough investigation was completed related to missing narcotics for 1 of 2 residents reviewed for abuse/misappropriation. (Resident 28) Finding includes: On 9/12/22 at 9:16 a.m. a Reportable Event was reviewed related to possible misappropriation of narcotics. The reportable indicated on 8/12/22, Resident 28 was sent to the hospital at 4:00 p.m. The resident had two Percocet (a narcotic pain medication) remaining in the medication cart. The record indicated one of the Percocet was signed out, date not legible, at 6 p.m., and the other signed out on 9/13/22 at 12:00 (no a.m. or p.m. noted), both when the resident was not in the facility. When it was discovered, the Administrator and Assistant Director of Nursing were notified and an investigation was initiated.	F 0610	The community was alleged to be out of compliance by failing to ensure a complete and thorough investigation was completed related to missing narcotics for 1 of 2 residents reviewed for abuse/misappropriation. **I. Specific Corrective Actions:** The ADON and Administrator were educated regarding investigation of abuse/misappropriation. The policy was reviewed in detail. **II. Identification and correction of others:** An audit of narcotics was completed, and no other residents were affected. **III. Systemic Changes:** The ADON and Administrator were educated regarding investigation of abuse/misappropriation. [Attachment: Abuse P&P]	10/14/2022

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	Interview with QMA 1 on 9/12/22 at 9:43 a.m., indicated her signature had been forged on the Medication Administration Record (MAR) for Resident 28's Percocet. Interview with the Director of Nursing (DON) on 9/12/22 at 10:10 a.m., indicated it was never determined what happened to the narcotics. QMA 1 had indicated her signature had been forged on the MAR. All nursing staff working around that time had been drug tested and everyone was negative. The Interim Director of Nursing had refused to be tested. The DON had not interviewed any residents or contacted law enforcement or any other agency. She had spoken to staff, but did not document interviews or collect any written statements. The investigation packet contained drug test results from six nurses working around that time and a copy of the inservice provided to nursing staff. There were no interviews or witness statements. The narcotics were signed out on the controlled drug record by a nurse whose signature allegedly had been forged. There was nothing related to a forged signature in the investigation. There was no indication law enforcement had been contacted. The current policy, "Abuse, Neglect and Exploitation", indicated, "...7. Investigation of abuse, neglect or exploitation...a. Interview the involved resident and document all responses...c. Interview all witness separately...obtain witness statements, according to appropriate policies. All statements should be signed and dated by the person making the statement. d. Document the entire investigation chronologically..." The policy also indicated, "...9. g. If a crime, or suspicion of a crime has occurred, notify the local law		**IV. <u>Monitoring:</u>** An audit will be completed by Administrator/designee weekly for 4 weeks, then monthly for at least 8 months. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: Reportable/Investigation CQI & QA Tracking Log]	

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	enforcement agency...." 3.1-28(d)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) discharge assessment was accurately completed for 1 of 15 MDS assessments reviewed. (Resident 45) Finding includes: The closed record for Resident 45 was reviewed on 9/12/22 at 1:52 p.m. The resident was admitted to the facility on 6/7/22 and discharged on 7/8/22. The Discharge MDS assessment, dated 7/8/22, indicated the resident was discharged to an acute hospital. A Nursing Note, dated 7/8/22, indicated the resident was discharged to home in good condition, with his family. Interview with the MDS Nurse on 9/12/22 at 2:13 p.m., indicated the MDS assessment was incorrect and she would correct it.	F 0641	F641 It is the policy of this facility to ensure that the Minimum Data Sets (MDSs) are accurate, especially related to discharge assessments and location to which the resident was discharged. **Specific Corrective Actions:** The records for Resident 45 were immediately corrected and/or updated regarding a discharge assessment. **II. Identification and correction of others:** All Minimum Data Set (MDS) discharge assessments were reviewed to ensure accurate coding for location of where the resident was discharged. **III. Systemic Changes:** MDS was educated by the MDS consultant to ensure accurate coding for discharge assessments. [Attachment: In-Service MDS 2022.] **IV. Monitoring:** The DON, ADON and/or designee will review 5 random MDS assessments weekly to ensure all	10/14/2022

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			discharge assessments are accurately completed. After 3 months the audits will decrease to bi-weekly and after 3 more months to monthly for a total of 9 months of auditing. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: Discharge MDS CQI/Audit Tool & QA Tracking Log]	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)			

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	(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on record review and interview, the facility failed to ensure comprehensive care plans were implemented related to medications for 2 of 15 resident care plans reviewed. (Residents 32 and B) Findings include: 1. Resident 32's record was reviewed on 9/12/22 at 9:48 a.m. The resident was admitted to the facility on 8/4/22. Diagnoses included, but were not limited to, a left hip fracture, depression and Diabetes Mellitus. A Physician's Order, dated 8/16/22, indicated the resident was to take Zoloft (an antidepressant) daily for depression. The current Psychotropic Medication Care Plan indicated the resident was on an antidepressant	F 0656	The community was alleged to be out of compliance by failing to ensure care plans were implemented related to medications for Resident 32 and Resident B. **I. <u>Specific Corrective Actions:</u>** The care plans for resident 32 and resident B were implemented and updated. **II. <u>Identification and correction of others:</u>** The care plans for all residents on psychotropics were reviewed to ensure goals and interventions were in place. The care plans for residents on diuretics were reviewed to ensure care plans were implemented. No other	10/14/2022

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	and anti-anxiety medications. The care plan did not have goals or interventions related to antidepressants; all goals and interventions were related to the anti-anxiety medication. Interview with the Minimum Data Set (MDS) Nurse on 9/13/22 at 9:55 a.m., indicated the care plan should have goals and interventions in place for both medications. It had been overlooked. 2. Resident B's record was reviewed on 9/8/22 at 12:18 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), type 2 diabetes mellitus, and vascular dementia with behavioral disturbance. The Annual MDS (Minimum Data Set) assessment, dated 7/20/22, indicated the resident received a diuretic medication. The Medication Administration Record (MAR), dated 9/2022, indicated the resident received Lasix (furosemide, a diuretic medication) 40 mg (milligrams) daily. There was lack of documentation of any care plan related to the diuretic medication. Interview with the MDS Nurse on 9/9/22 at 9:35 a.m., indicated there should have been a care plan in place for the diuretic medication and she may have resolved the care plan by accident. 3.1-35(a)		residents were identified. **III. <u>Systemic Changes:</u>** The MDS nurse was educated on care planning to include comprehensive and revisions. [Attachment: In-ServiceMDSPOC2022, Care Plan Revisions 20220520, Comprehensive Care Plans 20220520] **IV. <u>Monitoring:</u>** An audit will be completed by the DON/designee weekly for 4 weeks and then monthly for at least 8 months. The DON/designee will report findings to the QAPI committee monthly for review, recommendations, and tracking. [Attachment: Antidepressant or Diuretic Care Plan CQI & QA Tracking Log]	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

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	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to ensure a resident received the necessary care and treatment related to diarrhea for 1 of 1 residents reviewed for constipation and/or diarrhea. (Resident 32) Finding includes: On 9/7/22 at 10:03 a.m., Resident 32 was observed in her room. She was seated in a recliner watching TV. She indicated she was having bad diarrhea for the past two days. LPN 2 was notified at that time. The resident's record was reviewed on 9/12/22 at 9:48 a.m. The resident was admitted to the facility on 8/4/22. Diagnoses included, but were not limited to, a left hip fracture, depression and Diabetes Mellitus. A Nurse Note, dated 9/8/22, indicated the resident had complained of diarrhea to the Nurse Practitioner (NP). A one time order for immodium (an antidiarrheal medication) 2 milligrams, had been received. A Physician's Order, dated 8/9/22, indicated the resident received Miralax (a laxative) 17 grams, daily for constipation. The Medication Administration Record indicated Miralax had been given every day in September, including 9/7/22 and 9/8/22, the days the resident was complaining of diarrhea.	F 0684	It is the policy of this facility to provide quality care in relation to all treatments and care provided to our Residents and in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. **Specific Corrective Actions:** Resident 32's orders were updated to state Miralax should be held anytime the resident has diarrhea until the diarrhea resolves. **II. Identification and correction of others:** All residents were assessed to ensure anyone complaining of diarrhea are not receiving a laxative during the time he/she is experiencing diarrhea. **III. Systemic Changes:** All nursing staff were educated regarding notifying the MD to hold a laxative when residents' are experiencing diarrhea. [Attachment: In-ServiceNursing2022.] **IV. Monitoring:** The DON, ADON and/or designee will review 5 random charts weekly to ensure any resident experiencing diarrhea is not on a laxative at the same time. After 3	10/14/2022

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	Interview with the Director of Nursing on 9/13/22 at 10:23 a.m., indicated if the resident was having diarrhea she should not have been given Miralax. 3.1-37(a)		months the audits will decrease to bi-weekly and after 3 more months to monthly for a total of 9 months of auditing. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: Laxative/Antidiarrheal CQI]	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure proper supervision was provided with showering for 1 of 2 residents reviewed for accidents. (Resident B) Finding includes: On 9/7/22 at 1:36 p.m., Resident B was observed seated in her wheelchair in the hallway. She was propelling herself towards her room. She indicated she did not remember falling recently. Resident B's record was reviewed on 9/8/22 at 12:18 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary	F 0689	It is the policy of this facility to ensure proper supervision while providing a shower to a resident. **Specific Corrective Actions:** The nurse and CNA on the unit who left the resident unattended in the shower were given teachable moments. The nurse is no longer employed at this facility. **II. Identification and correction of others:** All residents who require extensive assist for bathing were checked to ensure staff knows not to leave the	10/14/2022

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	disease), type 2 diabetes mellitus, and vascular dementia with behavioral disturbance. The Annual MDS (Minimum Data Set) assessment, dated 7/20/22, indicated the resident was cognitively impaired, required an extensive assist of 2 for transfers and personal hygiene. She required an extensive assist of 1 for bathing. A Fall Risk Assessment, dated 7/23/22, indicated the resident was at high risk for falls. A Progress Note, dated 7/23/22 at 11:23 p.m., indicated the resident had an unwitnessed fall from the shower chair after attempting to get up and was found on the bathroom floor. She had lacerations to her right forehead and right knee and complained of right knee pain. The Nurse Practitioner was notified, and the resident was sent to the hospital for evaluation. The resident returned to the facility on 7/24/22 at 5:40 a.m. There was no indication of any further injuries or orders upon return to the facility. A Fall Investigation Report, dated 7/23/22 at 11:00 p.m., indicated staff had been assisting the resident with showering around shift change time. Other call lights were going off and staff left the resident in the shower alone to assist the other residents. Upon return to the resident's bathroom, she was found on the floor and indicated she was trying to get towels to dry off with. The root cause of the fall was the resident lost her balance attempting to dry herself off in the shower alone. Interview with the DON (Director of Nursing) on 9/8/22 at 1:59 p.m., indicated the staff would assist the resident in to the shower. She was mostly independent with washing herself and then she		resident alone in the shower. **III. <u>Systemic Changes:</u>** All nursing staff were re-educated regarding residents who require extensive assist for bathing are not left alone in the shower. [Attachment: In-ServiceNursing2022] **IV. <u>Monitoring:</u>** The DON, ADON and/or designee will review 5 residents who require extensive assist for bathing are not left alone in the shower. After 3 months the audits will decrease to bi-weekly and after 3 more months to monthly for a total of 9 months of auditing. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: Shower CQI & QA Tracking Log]	

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	would call staff when she was done to assist her with getting out of the shower. The nurse was assisting the resident, then went to answer call lights, and when he returned the resident was on the floor. The resident should not have been left alone in the shower. The nurse and the CNA working the night of the fall were given teachable moments. The nurse was no longer employed at the facility. This Federal tag relates to Complaint IN00386370. 3.1-45(a)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread			

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	155667	A. BUILDING 00 B. WING	09/14/2022

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OAK GROVE CHRISTIAN RETIREMENT VILLAGE	221 W DIVISION ST DEMOTTE, IN 46310

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	of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to ensuring each visitor was screened thoroughly before entering the facility for 1 of 5 visitors reviewed. (Visitor 1) Finding includes: On 9/7/22, 9/8/22, and 9/9/22 Visitor 1 entered the facility and completed the screening questions on the facility's kiosk. Each day, one of the screening questions answered by Visitor 1 caused her to be flagged in the system for review prior to entry. The kiosk had not printed a visitor sticker and a message was displayed that indicated she would receive a phone call from the facility. Visitor 1 never received any phone calls from the facility. Interview with the Director of Nursing on 9/9/22 at 3:30 p.m., indicated each visitor should answer the screening questions on the kiosk upon entering the facility. If any of the questions were flagged for review, it would alert on a facility phone. There was always a staff member assigned to be responsible for the phone and responding to any alerts. The staff member would then call the visitor and review the screening with them. She indicated on the above dates, the Unit Secretary and Receptionist were responsible for the phone and had not responded to the alerts. Staff should have called Visitor 1 and reviewed the screening questions with her.	F 0880	It is the policy of this facility to ensure all persons entering the facility are screened thoroughly for COVID-19 before entering the facility. **Specific Corrective Actions:** The person responsible to have the phone used to alert Oak Grove that there is a potential problem with a person entering the facility received a Team Member Coaching and Counseling Form immediately upon learning no one responded. She admitted she was not carrying the phone at the time it happened. [Attachment: TMC&C Form] **II. Identification and correction of others:** The log of visitors was reviewed to ensure no other persons entered the facility without a thorough screening. **III. Systemic Changes:** A second phone was added, so now there are two staff members carrying the phone used to alert the facility someone did not pass the screening questionnaire. One of these staff members will report to the kiosk and make sure no one with COVID-19 enters the facility. The 2 staff members	10/14/2022

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	The Indiana Department of Health COVID-19 Infection Control Guidance in Long-term Care Facilities, updated 2/8/22, indicated, "...Screen all persons who enter the facility; (e. g. visitors, vendors and HCP) for signs and symptoms of COVID-19 (e.g., questions about and observations of signs or symptoms) and deny entry to those with COVID-19 diagnosis, signs or symptoms, or those who have had close contact with someone with COVID 19 infection in the prior 10 days (regardless of the visitor's vaccination status). Visitors who have a positive viral test for COVID-19, symptoms of COVID-19 or meet the criteria for quarantine, should not enter the facility. Even if visitors and vendors have met the community criteria to discontinue isolation and quarantine, they should not visit if they have any of the following and have not met the same criteria for nursing home residents who have symptoms of COVID-19, have a positive viral test for COVID-19, or are a close contact with someone with COVID-19..." 3.1-18(b)		responsible for carrying the phone were in-serviced on protocol. [Attachment: InServiceF880POC2022] **IV. Monitoring:** The DON, ADON and/or designee will review the visitor log daily for 6 weeks to ensure no one has entered the facility without passing the screening questionnaire. After 6 weeks the audits will decrease to weekly, if compliant, and after 2 more months to monthly for 6 more months of auditing. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. The IP nurse/DON/designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with solutions identified during training. This will occur for 6 weeks and until compliance is maintained. [Attachment: Kiosk Audit Tool & QA Tracking Log]	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in	F 9999	It is the policy of this facility to ensure annual training in abuse and dementia are completed for all employees.	10/14/2022

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	advance for all personnel. This training shall include, but not be limited to, the following: (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure annual abuse training and dementia training was completed for 5 of 10 employee records reviewed. (QMA 1, LPN 1, Housekeeping 1, Cook 1, CNA 1) Finding includes: The employee records were reviewed on 9/12/22 at 11:20 a.m., and indicated the following: a. QMA 1 had only completed 2.5 hours of dementia training for 2021. b. LPN 1 had only completed 2.5 hours of dementia training for 2021. c. Housekeeping 1 had not completed any abuse training and only completed 1 hour of dementia training for 2021.		**Specific Corrective Actions:** We cannot correct training that was not received in 2021. **II. Identification and correction of others:** We cannot correct training that was not received in 2021. **III. Systemic Changes:** Nurse leadership made sure that there are 3 hours of dementia training loaded for each employee to complete in 2022. Housekeeper 1 is on Maternity Leave and will be expected to complete her abuse and dementia training immediately upon her return. **IV. Monitoring:** The Human Resource Director/or designee will audit compliance by reviewing the Relias completion by department weekly to ensure the abuse and dementia training are being completed. After 1 month the audits will decrease to monthly until the end of the year. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: POCMonitoringRelias2022 & QA Tracking Log] At the start of the new year HR will make sure the abuse and 3 hours of dementia training are loaded for each	

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	d. Cook 1 had only completed 2.5 hours of dementia training for 2021. e. CNA 1 had only completed 2.5 hours of dementia training for 2021.		employee to complete in 2023.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaint IN00386370. Complaint IN00386370 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: September 7, 8, 9, 12, 13, and 14, 2022. Facility number: 010823 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/16/22.	R 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Oak Grove Christian Retirement Village desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on October 14, 2022. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or			

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	date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure resident information was available in the Emergency Binder for 2 of 5 residents reviewed. (Residents 2 and 4) Findings include: 1. On 9/13/22 at 2:55 p.m., Resident 2's record was reviewed. There was no information for the resident in the Emergency Binder. 2. On 9/14/22 at 9:22 a.m., Resident 4's record was reviewed. There was no information for the resident in the Emergency Binder. Interview with the Director of Nursing on 9/13/22 at 2:38 p.m., indicated they did not currently have a Medical Records person, so the Emergency Binder had not been updated.	R 0356	R356 It is the policy of this facility to ensure resident information is available in the Emergency Binder. **Specific Corrective Actions:** Residents 2 and 4 immediately had their information added to the Emergency Binder. **II. Identification and correction of others:** The Emergency Binder was checked to ensure it contained information for all the residents residing on the second floor. **III. Systemic Changes:** Medical Records was educated to ensure all new admissions will be added to the Emergency binder. Medical Records will ensure all new admissions have their information added to the Emergency Binder. In the absence of Medicals Records the ADON will be responsible. [Attachment:	10/14/2022

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			In-ServiceMRPOC2022] **IV. Monitoring:** The MR Coordinator and/or designee will audit compliance by reviewing the Emergency Binder weekly. After 1 month the audits will decrease to monthly for 8 more months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: AL Emergency Binder CQI & QA Tracking Log]	