STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155667	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Grove Christian Retirement Village	221 W Division St Demotte, IN 46310

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to ensure a resident's representative was informed when a resident had a change in condition and required an order for breathing treatment medication for 1 of 3 residents reviewed for change in condition. (Resident B) Finding includes: Closed record review for Resident B was completed on 2/5/26 at 10:24 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), heart failure, hypertension, dementia, atrial fibrillation, and depression.The Quarterly Minimum Data Set (MDS) assessment, dated 10/31/25, indicated the resident was cognitively impaired. The resident received oxygen therapy.A Progress Note, dated 12/21/25 at 6:22 a.m., indicated the resident appeared to sleep well overnight. The staff indicated they had noticed a cough. The resident's lungs were clear.A Progress Note, dated 12/21/25 at 10:07 p.m., indicated a physician's order to administer albuterol sulfate inhalation nebulization solution (medication for breathing problems) via nebulizer two times a day for cough until 12/27/25.There was a lack of documentation to indicate the resident's representative was informed the resident had a change in condition and a new order for breathing medication was completed.During an interview on 2/5/26 at 1:43 p.m., LPN 1 indicated she did not document that she spoke with the resident's representative and inform them of the resident's change in condition and a new medication had been ordered. During an interview on 2/5/26 at 3:03 p.m., the Director of Nursing (DON) indicated the nurse should have documented that she spoke with the family related to the change in condition and medication change. This citation relates to Intake 2730697.3.1-3(n)(2)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on record review and interview, the facility failed to ensure a resident received the necessary care and treatment related to completing a respiratory assessment when a resident had a change of condition and completing pre-and-post assessments with breathing treatment medication for 1 of 3 residents reviewed for change of condition. (Resident B) Finding includes: Closed record review for Resident B was completed on 2/5/26 at 10:24 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), heart failure, hypertension, dementia, atrial fibrillation, and depression.The Quarterly Minimum Data Set (MDS) assessment, dated 10/31/25, indicated the resident was cognitively impaired. The resident received oxygen therapy.A Progress Note, dated 12/21/25 at 6:22 a.m., indicated the resident appeared to sleep well overnight. The staff indicated they had noticed a cough. The resident's lungs were clear.A Progress Note, dated 12/21/25 at 10:07 p.m., indicated a physician's order to administer albuterol sulfate inhalation nebulization solution (medication for breathing problems) via nebulizer two times a day for cough until 12/27/25.The December 2025 Medication Administration Record (MAR) indicated the resident had received the albuterol sulfate via nebulizer twice a day.There was a lack of documentation a respiratory assessment had been completed on the resident which indicated why the resident needed a new breathing treatment medication. The record also lacked any documentation pre-and-post respiratory assessments had been completed each time the albuterol sulfate nebulizer was administered. During an interview on 2/5/26 at 1:43 p.m., LPN 1 indicated a CNA had informed her the resident had a cough. She completed a respiratory assessment and contacted the physician, who then ordered the albuterol sulfate nebulizer medication. She did not document her assessment and she should have. She was unsure why there were no pre-and-post assessments each time the resident received the medication, but they should have been completed. During an interview on 2/5/26 at 3:03 p.m., the Director of Nursing (DON) indicated the nurse should have documented that a respiratory assessment was completed which indicated why the nebulizer medication was started. The staff should have completed pre-and-post assessments with each nebulizer treatment and she was unable to find any documentation they were completed.A facility policy, titled Nebulizer and received as current from the Administrator on 2/5/26, indicated, .6. Obtain resident's vital signs, and perform respiratory assessments to establish a baseline.This citation relates to Intake 2730697.3.1-47(a)(6)