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	04/14/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview, the facility failed to ensure a care planned intervention for bed mobility was followed related to lack of adequate staff supervision during care which resulted in a fall from the bed, for 1 of 4 residents reviewed for accidents. (Resident C)The deficient practice was corrected on 4/3/26, prior to the start of the survey, and was therefore past noncompliance. The facility identified the concern on 3/23/26, completed a house wide education to the nursing department and agency staff who provided care to utilize and follow the Care Plan/Kardex (information for caring for the resident) for all residents. Audits were completed to ensure the Care Plans/Kardexs were all correct and updated for resident care. Eight facility staff and agency staff were interviewed and indicated the Kardex was used as a reference for completion of resident care.Finding includes:Resident C's record was reviewed on 4/13/26 at 10:27 a.m. The diagnoses included, but were not limited to, dementia and osteoporosisThe resident's Kardexes, dated 7/7/25 and 3/22/26, indicated the resident required two staff members for bed mobility assistance.A Significant Change Minimum Data Set assessment, dated 1/21/26, indicated a moderately impaired cognitive status, an impairment to one side of the lower extremities, was dependent for bed mobility, and utilized a pressure reducing device for the bed.A Care Plan, revised on 1/28/26, indicated assistance for transfers was required. The interventions indicated two staff members were to be utilized for bed mobility.A Post Fall Evaluation, dated 3/22/26 at 1:34 a.m., indicated a fall occurred on 3/22/26 at 12:10 a.m. Agency CNA 1 had rolled the resident in bed while performing care without assistance and the resident fell from the bed. The resident was assessed and there were no injuries.The Investigation of the fall, dated 3/22/26, indicated Agency CNA 1 had been completing incontinence care without assistance. She had rolled the resident toward her and the resident's arm stretched out to the right side of the bed and caused her to start sliding from the bed. Agency CNA 1 ran to the side of the the bed and was able to break the fall. Agency CNA 1 indicated she was unaware the resident required two staff for bed mobility.During an interview on 4/13/26 at 10:49 a.m., the Director of Nursing (DON) indicated Agency CNA 1 had worked at the facility prior to 3/22/26. The Aide indicated she was on the right side of the bed and attempted to roll the resident toward her when her right arm flung out of the left side of the bed and she started to slip out the left side of the bed. She ran around the bed and was able to lower the resident to the floor. The DON had attempted to call the Aide to come in for a re-enactment to be completed and has had not return response from the aide. The resident was a two-person assist for bed mobility and this was on the Kardex.This citation relates to Intake 2977396.410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(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

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on record review and interview, the facility failed to ensure a resident was provided with medically-related social services related to follow up care for an allegation of abuse for 1 of 3 residents reviewed for abuse. (Resident D)Finding includes:Resident D's record was reviewed on 4/14/26 at 11:02 a.m. The diagnoses included, but were not limited to, dementia and Alzheimer's disease.A Significant Change Minimum Data Set assessment, dated 12/5/25, indicated a moderately impaired cognitive status, had other behaviors for one to three days and the behavior symptoms were worse.A Care Plan, dated 8/29/25, indicated anxiety was present and the resident would fixate on different things in regards to staff. The interventions included the staff would assist the resident to develop more appropriate methods of coping and interacting.An Indiana Department of Health reported incident, dated 2/3/26 at 10:30 a.m., indicated Resident D reported a CNA had shoved her in the chair and threw her walker. There were no injuries observed.A Care Plan, dated 2/4/26, indicated a history of making false allegations and exaggerations of the truth. The intervention included Social Service would be involved with the resident.There was no Social Service follow up after the allegation that monitored the resident psychosocial status.During an interview on 4/14/26 at 11:58 a.m., the Executive Director indicated at the time of the allegation, they had a staff member filling in for the Social Service Director. There was no policy that indicated the procedure for post abuse allegation care.The facility abuse policy, dated 7/15/25 and received per email from the Director of Nursing as current, indicated after an allegation was voiced, the resident would have increased monitoring and support.This citation relates to Intake 2961414.410 IAC (Indiana Administrative Code) 16.2-3.1-34(a)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on record review and interview, the facility failed to ensure laboratory (lab) services were only completed when ordered by a Physician/Nurse Practitioner (NP), related to a urinalysis (UA) completed on a resident without a Physician's Order, for 1 of 1 resident reviewed for lab tests. (Resident B)Finding includes:Resident B's record was reviewed on 4/14/26 at 8:21 a.m. The diagnoses included, but were not limited to, stroke and vascular dementia.A Progress Note, dated 3/23/26 at 11:35 a.m. and written by RN 1, indicated a urine specimen had been collected and the lab company was notified.There was no Physician/NP order for the urine specimen.During an interview on 4/14/26 at 10:06 a.m., RN 1 indicated the Director of Nursing (DON) requested the UA and she notified the NP. The resident had been catheterized for the urine collection.During an interview on 4/14/26 at 10:16 a.m., the DON indicated she had verbalized, we may want to get a UA, she had not directed RN 1 to get one and had assumed she would notify the NP for an order.410 IAC (Indiana Administrative Code) 16.2-3.1-49(f)(1)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure a resident's record was complete and accurate related to documentation of an allegation of abuse for 1 of 3 residents reviewed for abuse. (Resident D)Finding includes:Finding includes:Resident D's record was reviewed on 4/14/26 at 11:02 a.m. The diagnoses included, but were not limited to, dementia and Alzheimer's disease.An Indiana Department of Health reported incident, dated 2/3/26 at 10:30 a.m., indicated Resident D reported a CNA had shoved her in the chair and threw her walker. There were no injuries observed.There was no documentation of the allegation of abuse in the resident's record. During an interview on 4/14/26 at 11:58 a.m., the Executive Director indicated at the time of the allegation they had a staff member filling in for the Social Service Director. The facility abuse policy, dated 7/15/25, and received per email from the Director of Nursing as current, indicated actions taken would be documented.This citation relates to Intake 2961414.410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(1)410 IAC 16.2-3.1-50(a)(2)