

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Initial State Residential Licensure Survey completed on April 28, 2015.</p> <p>Survey dates: July 14, 15, 16, 17, 2015</p> <p>Facility number: 013613 Provider number: 013613 AIM number: N/A</p> <p>Census Bed Type: Residential: 9 Total: 9</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p>	R 0000	The Plan of Correction is to serve as Oasis Dementia Care's credible allegation of compliance. Submission of this Plan of Correction does not constitute an admission by Oasis Dementia Care or its management that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility. Nor does this submission constitute an agreement or admission of the survey allegations	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on observation and interview, the facility failed to report unusual occurrences, regarding elopement from the dementia care facility, to the Indiana State Department of Health for 1 of 1 residents in a total of 6 residents reviewed. (Resident #10)</p> <p>Findings include:</p> <p>The clinical record for Resident #10 was reviewed on 7/16/15 at 8:25 a.m. The record indicated the diagnoses included, but were not limited to, dementia with behaviors, hypertension, psychosis, anxiety, coronary artery disease, atrial fibrillation, reflux, anemia, iron deficiency, and vitamin D deficiency.</p> <p>A service plan dated 6/22/15, indicated elopement risk with an approach for staff to orient the resident to the environment.</p> <p>Nurses notes, dated 6/21/15 at 12:00 p.m., indicated the resident went LOA (leave of absence) with her daughter for over night pass and medications were sent with her. The resident returned early</p>	R 0090	<p>R 090</p> <p>The corrective action taken for those residents found to be affected by the alleged deficient practice include:</p> <p>The noted occurances will be reported to the Indiana State Department of health on or before 08/12/2015.</p> <p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</p> <p>As noted all residents had the potential to be affected.</p> <p>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</p> <p>The administrator reviewed policies and procedures pertaining to State Reportable Unusual Occurances to assure compliancy with current standards of practice.</p>	08/14/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>due to the resident being upset that she would not be allowed to stay in her home by herself. The resident exited the west door of the building and returned through the front entrance. The resident's daughter and the CEO (chief executive officer) were notified. No injuries were noted. Through investigation was lacking as to the length of time outside of the building.</p> <p>Nurses notes, dated 6/22/15 at 6:00 p.m., indicated the resident continued to be exit-seeking, setting door alarms off, and would not redirect.</p> <p>Nurses notes, dated 6/24/15 at 1:20 p.m., indicated the resident went LOA with the resident's daughter for admission to a hospital based behavioral unit.</p> <p>In an interview with QMA #1 on 7/16/15 at 9:05 a.m., indicated she was not working at the times the resident exited and attempted to exit the building on 6/21/15 and 6/22/15. She also indicated the resident had not attempted to exit since those times.</p> <p>In an interview with the Administrator on 7/16/15 at 10:00 a.m., he indicated exit doors had alarm systems and demonstrated the use of the alarm system on the west and south exits.</p>		<p>Staff was immediately instructed on the implementation of such. Staff will be evaluated on the policies and procedures throughout the week of 08/03/2015 - 08/07/2015. New Employee Orientation processes are being reviewed to assure they include orientation to policies and procedures pertaining to State Reportable Unusual Occurances. The corrective action taken to monitor performance to assure compliance through quality assurance is: As an ongoing quality improvement process the administrator or designee will complete an audit of new employee files reconciling the employee file with the revised "Employee File Audit (State Specific)" form dated 08/02/2015 to assure new employee orientation includes Abuse Prevention and Reporting of Unusual Occurances. Audits will be completed weekly x 4, monthly x 2, quarterly thereafter. Any noncompliances will be corrected immediately. Audit Summaries will be reviewed during weekly executive management</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0093 Bldg. 00	<p>A policy titled "State Reportable Unusual Occurrences" was provided by the Administrator on 7/14/15 at 3:30 p.m. The policy included, but was not limited to, the following: "A cognitively impaired resident who was found outside the facility whose whereabouts had been unknown."</p> <p>410 IAC 16.2-5-1.3(j)(1-4) Administration and Management - Noncompliance (j) If professional or diagnostic services are to be provided to the facility by an outside resource, either individual or institutional, an arrangement shall be developed between the licensee and the outside resource for the provision of the services. If a written agreement is used, it shall specify the following: (1) the responsibilities of both the facility and the outside resource; (2) the qualifications of the outside resource staff; (3) a description of the type of services to be provided, including action taken and reports of findings; and (4) the duration of the agreement.</p> <p>Based on record review and interview, the facility failed to provide an arrangement for 1 of 1 residents reviewed for hospice as the facility did not have a written agreement with the hospice provider. (Resident #4)</p> <p>Findings include:</p>	R 0093	<p>meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary</p> <p>R 093 The corrective action taken for those residents found to be affected by the alleged deficient practice include: A duplicate of the Hospice Agreement executed on 05/12/2015 was obtained and</p>	08/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>During an interview on 7/14/15 at 2:00 p.m., the Adm (Administrator) indicated Resident #4 was receiving hospice services.</p> <p>During record review on 7/14/15 at 2:17 p.m., the clinical record for Resident #4 indicated the resident was admitted on 5/12/15 from a local SNF/NF facility. The resident had received hospice services prior to the admission to the present facility.</p> <p>On 7/15/15 at 1:15 p.m., the Adm provided a hospice agreement with no signatures. The agreement was also not dated.</p>		<p>is currently on file.</p> <p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</p> <p>A record review indicated no other residents were contracted to receive hopice services.</p> <p>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</p> <p>A policy and procedure is being developed pertaining to professional or diagnostic services provided to residents by an outside resource. The administrator of designee will be advised of the request for outside service providers to assure appropriate systems are in place for the provision of services.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>As an ongoing quality improvement process the administrator or designee will complete an audit of resident records to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience		assure compliancy to established policies and procedures. Audits will be completed bi-weekly x2, monthly x2 and quarterly thereafter. Any noncompliancies will be corrected immediately. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to:</p> <p>(1) meet the needs or preferences, or both, of cognitively impaired residents; and</p> <p>(2) gain understanding of the current standards of care for residents with dementia.</p> <p>Based on record review and interview, the facility failed to designate a Director for the Memory Care Community, the facility. This had the potential to affect 9 of 9 residents in the facility.</p> <p>Findings include:</p> <p>During review of the employee list on 7/15/15 at 2:17 p.m., the employee list indicated the facility did not have a designated dementia program director.</p> <p>During an interview on 7/15/15 at 3:30 p.m., the Administrator indicated the facility did not have a dementia program director. The Administrator further indicated the facility would need to be cited for this.</p> <p>A policy book was obtained from the Administrator on 7/14/15 at 1:20 p.m. The policy book did not contain a policy</p>	R 0095	<p>R 095</p> <p>The corrective action taken for those residents found to be affected by the alleged deficient practice include:</p> <p>A policy and procedure is being written and implemented pertaining to the appointment of a Dementia Unit Program Director.</p> <p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</p> <p>As noted all residents had the potential to be affected.</p> <p>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</p> <p>It is the policy of Oasis Dementia</p>	08/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	for a dementia program director or a job description.		<p>Care that a qualified person be employed and designated as the Dementia Program Unit director</p> <p>A facility staffing tool is being utilized to list all staffing positions noting the title and the employee specifically designated for the position.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>As an ongoing quality improvement process the administrator will review and audit required staffing positions to assure each position is appropriately filled.</p> <p>Audits shall be completed weekly x 4, monthly x2, quarterly thereafter. Any non-compliant practices will corrected immediately.</p> <p>Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0117 Bldg. 00	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interview, the facility failed to ensure at least one staff member was on duty at all times who was certified in CPR (cardiopulmonary resuscitation) and First Aide for 2 (two) week period. This had the potential to affect 9 (nine) of 9 residents at the facility.</p>	R 0117	<p>necessary.</p> <p>R 117 The corrective action taken for those residents found to be affected by the alleged deficient practice include: Employee files were organized to assure the CPR and First Aid Certificates on hand were</p>	08/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Findings include:</p> <p>The staffing schedule was provided by the Administrator (Adm) on 7/14/15 at 1:10 p.m. The schedule was reviewed for the time period of 6/27/15 - 7/10/15.</p> <p>The employee files were provided by the Administrator (Adm) on 7/15/15 at 3:00 p.m. During review of employee files on 7/15/15 at 3:05 p.m., the CPR or first aide certifications were not located in the files.</p> <p>During an interview with the Adm on 7/15/15 at 3:10 p.m., the Adm indicated he did not have a staff member with CPR or first aide certification on the schedule from 6/27/15 - 7/10/15. The Adm indicated the staff with CPR had received the training on-line.</p> <p>During an interview with the Adm on 7/15/15 at 4:00 p.m., the Adm indicated no employees had CPR accreditation and certification by qualified associations. The Adm indicated the facility would need to be cited.</p> <p>The facility lacked a policy regarding CPR or first aide certification.</p>		<p>placed in the individual employee files and not maintained in a separate binder/folder. Policies and Procedures pertaining to CPR/First Aid Certification will be revised to be compliant with the ISDH stance on CPR/First Aid acceptable practices. Licensed and certified personnel requiring CPR/First Aid recertification have been notified and will be required to meet the mandatory requirements.</p> <p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</p> <p>As noted all residents had the potential to be affected.</p> <p>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</p> <p>Employee Job Descriptions and Requirements are being reviewed and revised to assure compliancy. The job descriptions will be reviewed with the employees holding the designated positions An "Employee File Audit" form (revised 08/02/15)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			<p>is being utilized as a guide during the hiring and orientation process. The tool is to be completed by the administrator or designee to assure a new employee meets the requirements of a position and supporting documentation is included in the employee file.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>As an ongoing quality improvement process the administrator will complete an employee file audit on an ongoing basis for each new employee reconciling the "Employee File Audit" form to the employee file. Audits shall be completed weekly x 4, monthly x2, quarterly thereafter. Any non-compliant practices will corrected immediately. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

R 0120 Bldg. 00	<p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance</p> <p>(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following:</p> <p>(A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice.</p> <p>The employee will acknowledge attendance by written signature.</p>		interventions are necessary.	
--------------------	--	--	------------------------------	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Based on record review and interview, the facility failed to ensure inservices were provided for 3 of 10 employees reviewed for Resident Rights training and Abuse training inservices. (LPN #1, CNA #3, RN #1)</p> <p>Findings include:</p> <p>During record review on 7/16/15 at 1:15 p.m., the employee files (LPN #1, CNA#3, RN #1) indicated the Resident Rights and Abuse training had not been completed.</p> <p>A policy titled, "Abuse Prevention Plan" obtained from the Administrative Assistant on 7/16/15 at 2:13 p.m., indicated the facility would have an on-going program for training employees on abuse.</p> <p>During an interview on 7/17/15 at 1:40 p.m., the Administrator indicated the training had been completed on Resident Rights and Abuse but the above employees had not attended the inservice</p>	R 0120	<p>R 120</p> <p>The corrective action taken for those residents found to be affected by the alleged deficient practice include:</p> <p>No specific residents were identified.</p> <p>LPN #1 and CNA #3 have been inserviced on Resident Rights, Abuse Prevention & Reporting Resident Rights, Abuse Prevention and Reporting of Unusual Occurances are inclusive in New employee orientation.</p> <p>An annual Inservice Schedule will be developed and implemented. Topics will include but are not limited to Residents Right, Abuse Prevention and Reporting of Unusual Occurances.</p> <p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</p> <p>All residents had the potential to be affected</p> <p>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur</p>	08/16/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			<p>include: Policy and Procedures pertaining to new employee orientation are being reviewed to assure the inclusion of orientation to policies and procedures pertaining to Resident Rights, Abuse Prevention and Reporting of Unusual occurrences. Inservices will be pre-planned annually based upon noted requirements per regulations as well as recommendations of the executive management team. The administrator or designee will complete monthly audits to assure compliancy to the planned inservice schedule. The corrective action taken to monitor performance to assure compliance through quality assurance is: As an ongoing quality improvement process the administrator or designee will complete random audits of employee files hired since the previous audit date to assure compliancy to orientation procedures. Audits will be completed weekly for any new hires x 4, monthly x 2, quarterly thereafter.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin		The administrator or designee will complete monthly audits to assure compliancy to the planned inservice schedule. Any non-compliancy will be correct immediately. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on record review and interview, the facility failed to ensure tuberculosis testing were completed for 1 of 10 employees. (CNA #3)</p> <p>Findings include:</p> <p>During record review on 7/16/15 at 1:15 p.m., the employee files indicated CNA #3 was hired on 5/11/15. The employee file indicated CNA #3 had not received the second step tuberculosis test</p> <p>A policy titled, "Mantoux Testing Policy," obtained from the Administrator</p>	R 0121	<p>R 121</p> <p>The corrective action taken for those residents found to be affected by the alleged deficient practice include:</p> <p>CNA # 3 was identified and initiated a two step PPD testing process. All employee files will be audited to assure compliancy.</p> <p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</p> <p>All residents had the potential to be affected</p>	08/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>on 7/17/15 at 1:05 p.m., indicated all new employees would have a two-step Mantoux test for tuberculosis.</p> <p>During an interview with the Administrator, on 7/17/15 at 1:40 p.m., indicated he had noticed CNA #3 was lacking the second step when he reviewed the employee files on 7/16/15.</p>		<p>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</p> <p>Policy and Procedures have been revised to assure compliancy with standards pertaining to employee tuberculin skin tests. An Employee File Audit form was developed on 08/02/2015 to be used as an auditing tool in assuring the compliancy of employee health screening.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>As an ongoing quality improvement process the administrator or designee will complete an audit of each new employee file reconciling the employee file with the "Employee File Audit" form (revised 08/02/15) to assure compliancy to established pre-employment health screening policy and procedures including but not limited to an assessment for tuberculosis. Audits will be completed weekly for any new</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation.		hires x 4, monthly x 2, quarterly thereafter. Any non-compliances will be immediately corrected. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Based on record review and interview, the facility failed to ensure employee records were complete and accurate for 1 of 10 employees. The file did not contain a general or specific job description for the employee. (Chef #1)</p> <p>Findings include:</p> <p>The employee files were provided by the Administrator (Adm) on 7/16/15 at 1:15 p.m.</p> <p>During review of the employee files on 7/16/15 at 1:15 p.m., Chef #1 did not have a general or specific job description in the file.</p> <p>During an interview with the Adm on 7/17/15 at 1:40 p.m., the Adm indicated facility did not have a specific or general job description for any of the employees. The Adm further indicated the facility lacked a policy regarding job descriptions for the employees.</p>	R 0123	<p>R 123</p> <p>The corrective action taken for those residents found to be affected by the alleged deficient practice include:</p> <p>No specific residents were identified.</p> <p>Job Descriptions are being written and reviewed with current employees including but not limited to chef # 1.</p> <p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</p> <p>All residents had the potential to be affected</p> <p>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</p> <p>Employee policies and procedures are being reviewed and revised to assure the availability of Job Descriptions and the employee review and acknowledgement of such. An Employee File Audit form was developed on 08/02/2015 to be used as an auditing tool in assuring complete and accurate</p>	08/14/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0149	410 IAC 16.2-5-1.5(f)		<p>employee recordsn are maintained.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>As an ongoing quality improvement process the administrator or designee will complete an audit of each new employee file reconciling the employee file with the "Employee File Audit" form (revised 08/02/2015) to assure compliancy to established employee policies and procedures. Audits will be completed weekly for any new hires x 4, monthly x 2, quarterly thereafter. Any non-compliancies will be immediately corrected. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
Bldg. 00	<p>Sanitation and Safety Standards - Deficiency (f) The facility shall have a pest control program in operation in compliance with 410 IAC 7-24.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a pest control program was in operation as ants were streaming from an exit door into the kitchen and crawling on boxes, found in the conference room on the refrigerator and tables. This has the potential to affect 9 of 9 residents in the facility.</p> <p>Findings include:</p> <p>On 7/14/15 at 1:39 p.m., a tour of the kitchen indicated lines of ants traveling from one wall to another, crawling on boxes of Uncle Bens Rice, a box of individual packages of mayonnaise, box of individual Saltine Crackers packages, and a box with two sealed bags of Medium Egg Noodles, which were sitting on a crate. The ants were also noted in mass, at the exit door in the dining room crawling into the kitchen.</p> <p>On 7/14/15 at 1:45 p.m., an interview with the Chef #1 indicated that ants were a problem and someone had been to spray recently and management was aware.</p> <p>On 7/14/15 at 2:00 p.m. ants were</p>	R 0149	<p>R 149</p> <p>The corrective action taken for those residents found to be affected by the alleged deficient practice include:</p> <p>The pest control company with whom the facility has a contractual agreement was notified for a service request. Service was provided on 07/07/15. The area was cleaned prior to being serviced. A Policy and Procedure was written and implemented immediately. A copy of the signed Pest Control Agreement was obtained and maintained on file.</p> <p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</p> <p>All residents had the potential to be affected</p> <p>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur</p>	08/16/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>observed in the open conference room on the tables.</p> <p>On 7/14/15 at 4:00 p.m., the Administrator was queried about the ants. He indicated someone had been here about two weeks ago to spray for the ants.</p> <p>On 7/14/15 at 5:00 p.m., it was observed the trail of ants was still present from exit door into the kitchen and crawling onto boxes and shelving. Also noted under the drinking fountain was a box of non poisonous mouse and insect glue board, which states keep out of reach of children. The box was dated Jan 2015. Observation in the box indicated a few ants, spiders and black bugs.</p> <p>On 7/15/15 at 8:30 a.m., during an observation of the kitchen and dining room, it was observed to have ants crawling from the exit door, on the kitchen wall, over boxes and shelving.</p> <p>On 7/15/15 at 8:32 a.m., interview with Chef #1 indicated she notified the Administrator that the ants would be a problem when the surveyors came, and she thought someone was going to spray today. Chef #1 also indicated her boss Chef #2 instructed her to move the boxes with ants crawling on them to the dry</p>		<p>include:</p> <p>The Policy and Procedure pertaining to pest control has been reviewed and implemented. Employees were instructed on the proper action to take to report a need for interventions between the regularly scheduled monthly service.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>As an ongoing quality improvement process the administrator or designee will audit the Pest Control Records monthly to assure compliance with the pest control program. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>storage room.</p> <p>On 7/15/15 at 10:00 a.m., a contract of pest control was received from the Administrator. The contract indicated the company had been to the facility on 1/15/15, 2/10/15, 3/9/15, 5/13/15, and 6/12/15. On each visit the kitchen, exit door, game room, and nurses station was treated with Advion (a insecticide) gel spray or gel boxes. It was advised repeatedly by the pest control company to seal gaps in door entry and holes under sink to help prevent ant entry.</p> <p>On 7/15/15 at 10:30 a.m. ants were observed in the open conference room on the refrigerator exterior and the conference room tables.</p> <p>On 7/15/15 at 11:30 a.m., the boxes with ants crawling on them, were each inspected. Inside the boxes, for which ants may have been able to access the inside of the packages, no ants were found.</p> <p>The MSDS (Material Safety Data Sheet) for Advion was reviewed on 7/15/15. The MSDS indicated hazards for Human and Domestic Animal as follows: Keep out of reach of children. Avoid contact with children. "Avoid contact with skin, eyes and clothing. Wash thoroughly with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>soap and water". It also stated the product has no known adverse effects on human health. First Aid measures include, calling the Syngenta Company, Poison Control, doctor, or going for treatment. If swallowed, have the person sip glass of water if able to swallow or call the above persons. If there is eye contact, rinse gently with water for 15-20 minutes or call emergency personnel. If on skin or clothing, rinse skin immediately with plenty of water for 15-20 minutes or call emergency personal. For inhalation, move the person to fresh air, and if not breathing call 911.</p> <p>On 7/16/15 at 8:50 a.m., the ants were observed in the exit door and trailing into the kitchen along the walls. The boxes have been removed.</p> <p>On 7/17/15 at 2:45 p.m. the facility lacked a policy for pests.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
R 0154 Bldg. 00	<p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the kitchen and kitchen areas were clean and in good repair. The kitchen floors were not clean. In Gigi's kitchen (a small kitchen accessible to the residents), the refrigerator was dirty, a covered cookie and an open bag of soup crackers were unlabeled and undated, and a bowl of apple pie was in refrigerator unlabeled and undated. This has the potential to affect 9 of 9 residents in the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 7/14/15 at 1:45 p.m., during observation of the kitchen, the kitchen floors were dirty with debris and dirt buildup was observed in the corners of the room. On 7/14/15 at 1:55 p.m., during an observation of Gigi's kitchen (a smaller kitchen the residents have access to), the following was observed in the refrigerator: 	R 0154	<p>R 154 The corrective action taken for those residents found to be affected by the alleged deficient practice include: Any dirt or debris noted on the floor was not an accumulation of such. The floor is cleaned nightly as well as deep cleaned on a weekly basis. The refrigerator in GiGi's kitchen has since been deep cleaned. Cleaning schedules are being written and implemented. Staff will be in-serviced on the schedules and proper documentation of completion of assignments. Other residents that have the potential to be affected by the alleged deficient practice have been identified by: All residents had the potential to be affected The measures or systematic changes that have been put into place to ensure that the</p>	08/16/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>A. The refrigerator was soiled with dirt debris and old vegetable scraps.</p> <p>B. A cookie was covered with a paper towel with no date or label on it.</p> <p>C. An open bag of soup crackers were undated and unlabeled</p> <p>D. A bowl of apple pie was unlabeled and undated in the refrigerator,</p> <p>On 7/15/15 at 9:00 a.m. and 3:27 p.m. the kitchen's were re-observed and noted to be unchanged.</p> <p>On 7/15/15 at 3:18 p.m., interview with Administrator indicated that housekeeping has a schedule which was received, undated and titled "Housekeeping". The policy indicated that cleaning of refrigerators and floors are to be done on Sundays for deep cleaning and Wednesdays for light cleaning in Gigi's kitchen and the main kitchen flooring is cleaned daily.</p>		<p>alleged deficient practice does not recur include: Cleaning schedules are being written and implemented. Staff will be in-serviced on the schedules and proper documentation of completion of assignments. The corrective action taken to monitor performance to assure compliance through quality assurance is: As an ongoing quality improvement process the consulting dietician will complete a monthly audit of dietary services including but not limited to the completion and documentation of the of cleaning assignments. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

R 0217 Bldg. 00	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to review or revise the service plans for 2 of 6 residents reviewed for service plans. The residents had new behaviors including threatening other residents, and staff during care resulting in the resident receiving</p>	R 0217	<p>R 217 The corrective action taken for those residents found to be affected by the alleged deficient practice include: The service plans of residents #3 & #4</p>	08/16/2015
------------------------	---	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>antipsychotic drugs, hospice care and multiple falls. (Resident #3, Resident #4)</p> <p>Findings include:</p> <p>1. During an interview on 7/15/15 at 8:05 a.m., LPN #1 indicated Resident #3 had threatened another resident in May, 2015. LPN #1 indicated she did not remember who the other resident was but that Resident #3 had also threatened a staff member on the same day.</p> <p>The clinical record for Resident #3 was reviewed on 7/14/15 at 3:05 p.m. Resident # 3 had clinical diagnoses including, but not limited to, Alzheimer's dementia, chronic kidney disease, hypertension, hyperlipidemia, and diabetes mellitus type 2.</p> <p>A nurse's note, dated 5/3/15 at 7:25 a.m., indicated Resident #3 had made a verbal threat to another resident with no physical alteration noted.</p> <p>A nurse's note, dated 5/3/15 at 8:00 p.m., indicated Resident #3 was argumentative with a staff member who was performing care to another resident.</p> <p>The service plan, signed on 5/15/15, did not indicate a need for behavior tracking or any behavior modifications for the</p>		<p>are being reviewed and revised to assure the inclusion of any behavioral issues. Policies and Procedures pertaining to Behavioral Management and implementation into the Resident Service Plan are being reviewed to assure continuity in the provision of services</p> <p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</p> <p>All residents had the potential to be affected</p> <p>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</p> <p>Upon completion of the review process appropriate staff will be inserviced on the implementation of the Behavioral Management Plan. New Employee Orientation procedures are being reviewed to assure the inclusion of training pertaining to the Behavioral Management Plan with inclusion into the Resident Service Plan.</p> <p>The corrective action taken to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>resident.</p> <p>2. During an interview with LPN #1 on 7/15/15 at 2:15 p.m., LPN #1 indicated Resident #4 had fallen in the past and had some behaviors against the staff. LPN #1 indicated the resident had been receiving hospice services at the facility and had received Seroquel (an antipsychotic) in which he had an adverse reaction. LPN #1 indicated the hospice nurse had ordered the Seroquel from the hospice Medical Director but had not discussed the medication with the resident's primary physician prior to ordering the medication.</p> <p>The clinical record and hospice record of Resident #4 was reviewed on 7/14/15 at 2:17 p.m. Resident #4 had diagnoses including, but not limited to, dementia, prostate cancer, chronic obstructive pulmonary disease, anxiety, and chronic kidney disease.</p> <p>A nurse's note, dated 6/16/15 at 1:00 p.m., indicated Resident #4 had increased behavior before ADL (activities of daily living) care. The note indicated the hospice nurse had obtained an order for Ativan (an antianxiety medication) 0.25 mg (milligram) 1 (one) tablet bid (twice a day) prn (as needed) to be given before</p>		<p>monitor performance to assure compliance through quality assurance is: As an ongoing quality improvement process upon notification of a referral due to behavioral concerns the administrator or designee will complete a record audit to assure proper implementation of the Behavioral Management Plan including but not limited to the inclusion of such plan into the Resident Service Plan. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>ADL care related to increased behaviors from the hospice Medical Director.</p> <p>A nurse's note, dated 6/17/15 at 10:00 p.m., indicated Resident #4 had been very restless and was cursing at the staff. The note further indicated the resident indicated they were hearing voices through the pillow.</p> <p>A nurse's note, dated 7/7/15 at 8:50 a.m., indicated Resident #4 had a fall in the hall while conversing on the telephone.</p> <p>A nurse's note, dated 7/10/15 at 10:00 a.m., indicated the hospice nurses obtained an order for Seroquel (an antipsychotic medication) 25 mg (milligram) po (orally) tid (three times a day) from the hospice Medical Director. The note indicated the resident refused ADLs consistently and would not allow the hospice nurse to finish trimming their nails.</p> <p>A nurse's note, dated 7/10/15 at 8:00 p.m., indicated the Seroquel was not given due to Resident #4 being unsteady, shaky, and slightly confused.</p> <p>A nurse's note, dated 7/11/15 at 2:45 a.m., indicated Resident #4 was found on the floor with no injuries. No further documentation was noted.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>During an interview with LPN #1 on 7/15/15 at 2:15 p.m., LPN #1 indicated Resident #4 had fallen in the past and had some behaviors against the staff. LPN #1 indicated the resident had been receiving hospice services at the facility and had received Seroquel (an antipsychotic) in which he had an adverse reaction. LPN #1 indicated the hospice nurse had ordered the Seroquel from the hospice Medical Director but had not discussed the medication with the resident's primary physician prior to ordering the medication.</p> <p>The service plan, signed on 5/29/15, had not been reviewed or revised to indicate the increased behaviors or the falls.</p> <p>A policy titled, "Resident Service Plan," undated and obtained from the Administrator on 7/17/15 at 1:05 p.m., indicated the services offered would be appropriate to the scope, frequency, need, and preference of each resident. The policy indicated the service plan would reflect the functional level of the resident or intervention provided for the assessment areas. The policy further indicated all health care staff would be responsible for review of the resident's service plan.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on interview and record review, the facility failed to obtain physician orders for a medication and hospice services for 1 of 6 residents reviewed for physician orders. A resident received hospice services without an order and the resident was given a medication ordered by a hospice physician which was not approved or acknowledged by the resident's primary care physician.</p>	R 0241	<p>R 241 The corrective action taken for those residents found to be affected by the alleged deficient practice include: The resident was discharged from hospice on 07/24/2015. Policies and Procedures pertaining to Physician Services are being</p>	08/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>(Resident #4)</p> <p>Findings include:</p> <p>During an interview on 7/14/15 at 1:10 p.m., the Adm (Administrator) indicated Resident #4 had been receiving hospice services.</p> <p>The clinical record and hospice record of Resident #4 was reviewed on 7/14/15 at 2:17 p.m. Resident #4 had diagnoses including, but not limited to, dementia, prostate cancer, chronic obstructive pulmonary disease, anxiety, and chronic kidney disease. The facility clinical record indicated Resident #4 had a primary physician and a specialist listed on the resident information sheet. The hospice clinical record indicated Resident #4 had a different primary physician and the hospice medical director as the physicians who should be notified.</p> <p>Resident #4 had a physician's order, dated 7/10/15 at 9:30 a.m., for Seroquel (an antipsychotic medication) 25 mg (milligram) po (orally) tid (three times a day). The medication order had been received from the hospice medical director by the hospice nurse.</p> <p>Resident #4 had a physician's order, dated 7/11/15 at 9:34 a.m., which indicated the</p>		<p>reviewed and revised as needed to assure the inclusion of specific procedures pertaining to orders received from ancillary service providers.</p> <p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</p> <p>All residents had the potential to be affected.</p> <p>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</p> <p>Upon completion of the review process appropriate staff will be inserviced on the policies and procedures pertaining to Physician Services and Notification. New Employee Orientation procedures are being reviewed to assure the inclusion of training pertaining to the Physician Services and Notification.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>As an ongoing quality</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Seroquel was to be discontinued. The physician's order was received from the nurse practitioner associated with the resident's primary care physician.</p> <p>A nurse's note, dated 7/10/15 at 10:00 a.m., indicated the hospice nurse reported Resident #4 refused ADLs (activities of daily living) consistently and would not allow the hospice nurse to trim his nails. The note further indicated the hospice nurse notified the hospice medical director and received the Seroquel order.</p> <p>A nurse's note, dated 7/11/15 at 9:45 a.m., indicated the primary care physician's nurse practitioner was notified of the new orders for Seroquel and the resident's increased confusion.</p> <p>During an interview on 7/15/15 at 10:15 a.m., LPN #1 indicated Resident #4 had been receiving hospice services since entering the facility. LPN #1 indicated she did not really know who the primary care physician was for Resident #4. LPN #1 indicated the resident's hospice chart listed a primary care physician and the hospice medical director as the resident's physician and Resident #4's medical record at the dementia facility listed 2 (two) different physicians as the resident's primary care physicians. LPN #1 indicated the hospice medical director</p>		<p>improvement process the administrator or designee will complete audits of resident physician orders to assure compliancy to established policy and procedures. Audits shall be completed weekly x 4, monthly x2, quarterly thereafter. Any non-compliant practices will corrected immediately. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>was the physician who had initially ordered the Seroquel on 7/10/15 at 9:30 a.m. Upon query, LPN #1 indicated Resident #4's primary care physician was not notified prior to the resident receiving the Seroquel.</p> <p>During an interview on 7/15/15 at 10:20 a.m., hospice RN #1 indicated Resident #4 was admitted from a SNF/NF facility, at which time the resident had physician A. Resident #4 was transferred to the dementia facility with primary care physician B. Hospice RN #1 indicated she did not know who the primary care physician was for Resident #4 at the dementia facility. Hospice RN #1 indicated the hospice staff should have notified the resident's primary care physician before contacting the hospice medical director regarding Resident #4's condition.</p> <p>During an interview with LPN #1 on 7/15/15 at 10:30 a.m., LPN #1 indicated the facility did not have a physician's order for hospice services at the facility.</p> <p>During an interview on 7/15/15 at 11:10 a.m., the Adm (Administrator) indicated the facility did not have an order for hospice services for the resident but the Adm indicated the resident had transferred from another facility where he</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>had the hospice services. The Adm indicated Resident #4 did not have the same primary physician that the resident had at the prior facility. The Adm indicated the hospice chart was incorrect in identifying the primary physician. The Adm indicated the resident's primary physician at the facility was the correct name on the face sheet. The Adm indicated the specialist name listed on the face sheet was the nurse practitioner associated with the primary physician listed and not a physician, as the name was deemed. The Adm indicated the resident had an adverse reaction to the Seroquel and the Adm had the primary physician notified.</p> <p>During an interview with LPN #1 on 7/15/15 at 2:15 p.m., LPN #1 indicated Resident #4 had fallen in the past and had some behaviors against the staff. LPN #1 indicated the resident had been receiving hospice services at the facility and had received Seroquel (an antipsychotic) in which he had an adverse reaction. LPN #1 indicated the hospice nurse had ordered the Seroquel from the hospice Medical Director but had not discussed the medication with the resident's primary physician prior to ordering the medication.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0302 Bldg. 00	<p>The facility lacked a policy regarding receiving physician's orders for provision and supervision of care.</p> <p>410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength.</p> <p>Based on interview and observation, the facility failed to ensure OTC (over-the-counter) medications were labeled for 4 of 9 residents. The OTC meds did not have a resident name or physician name on them. (Resident #2, Resident #3, Resident #8, Resident #9)</p> <p>Findings include:</p> <p>1. During an interview on 7/15/15 at 8:20 a.m., LPN #1 indicated several medications in bottles were brought in, for the residents, to be administered by</p>	R 0302	<p>R302 The corrective action taken for those residents found to be affected by the alleged deficient practice include: A Policy and Procedure has been written and implemented pertaining to the labeling of over-the-counter medications. All over-the-counter medications have been identified and the labeling of such is in compliance with established policies and procedures.</p>	08/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>their families. Upon query, LPN #1 indicated the medications did not have labels on them. LPN #1 indicated the facility did not have any residents who were self-administering their medications.</p> <p>2. During an observation of the medication cart on 7/15/15 at 11:35 a.m., the following over-the-counter medications were observed for Resident #2 I-cap (a vitamin for the eyes) and Aspirin 81 mg enteric coated.</p> <p>3. During an observation of the medication cart on 7/15/15 at 11:36 a.m., the following over-the-counter medication were observed for Resident #3: Tylenol Extra Strength 500 mg (milligram).</p> <p>4. During an observation on 7/15/15 at 11:37 a.m., the following over-the-counter medications were observed for Resident #8: Docusate Sodium 50 mg/Sennoside 8.6 mg (a laxative).</p> <p>5. During an observation on 7/15/15 at 11:38 a.m., the following over-the-counter medications were observed for Resident #9: One-a-Day Vitamin 50+, Bayer Aspirin 81 mg,</p>		<p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by: All residents had the potential to be affected The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include: A Policy and Procedure has been written and implemented pertaining to the labeling of over-the-counter medications. Appropriate staff will be inserviced on the policies and procedures pertaining to the labeling of over-the-counter medications. New Employee Orientation procedures are being reviewed to assure the inclusion of training pertaining to the labeling requirements of over-the-counter medications. The corrective action taken to monitor performance to assure compliance through quality assurance is: As an ongoing quality improvement process the administrator or designee will complete audits of the medicine carts to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
R 0328 Bldg. 00	<p>Vitamin D3 5000 U (units), DHEA 50 mg (a supplement), Vitamin B-12 1000 mcg (microgram), Neuro-PS Gold (a supplement), Enhanced Turmeric Formula (a supplement), Resvatrol 250 mg (a supplement), L-Taurine 1000 mg (a supplement), Vitamin B-50, Benagene (an anti-aging supplement), Vitamin D3 1000 IU (international units), and Cirecomp (a supplement).</p> <p>The facility lacked a policy for over-the-counter medications.</p> <p>410 IAC 16.2-5-7.1(c)(1-3) Activities Programs - Noncompliance (c) An activities director shall be designated and must be one (1) of the following: (1) A recreation therapist. (2) An occupational therapist or a certified occupational therapy assistant. (3) An individual who has satisfactorily completed or will complete within one (1) year an activities director course approved by the division.</p> <p>Based on observation, record review and interview, the facility failed to ensure an activity director was designated. This</p>	R 0328	<p>assure over-the-counter medications are labeled appropriately. Audits shall be completed weekly x 4, monthly x2, quarterly thereafter. Any non-compliant practices will corrected immediately. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary.</p> <p>R 328 The corrective action taken for those residents found to be affected</p>	08/16/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>had the potential to affect 9 of 9 residents.</p> <p>Findings include:</p> <p>During an observation on 7/15/15 at 9:40 a.m., AAD (Assistant Activity Director) was providing exercises with the residents.</p> <p>During an observation on 7/15/15 at 11:45 a.m., the AAD was observed to be exercising with the residents.</p> <p>During a review of the activity calendar on 7/15/15 at 11:45 a.m., the calendar indicated the residents were to have to have "Exercises" at 9:30 a.m., "In the Kitchen" at 10:00 a.m., and "Cards" at 11:00 a.m.</p> <p>During an interview with LPN #1 on 7/15/15 at 9:50 a.m., LPN #1 indicated the exercise activity was started approximately 5 minutes late. LPN #1 indicated the Marketing person would make out the activity schedule for the residents and the facility did not have a designated activities director.</p> <p>During an interview on 7/15/15 at 11:50 a.m., the AAD indicated she was a COTA (certified occupational therapy assistant). The AAD indicated she was</p>		<p>by the alleged deficient practice include:</p> <p>The AAD will be designated as the AD.</p> <p>A Policy and Procedure regarding activities and the appointment of an AD is being developed.</p> <p>To clarify the findings noted the Marketing Director was also the Program Director Specific to Activities and her duties included the development of the activity program/calendar.</p> <p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</p> <p>All residents had the potential to be affected</p> <p>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</p> <p>A Policy and Procedure is being written and implemented pertaining to an activity program.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>As an ongoing quality</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
R 0356 Bldg. 00	<p>not the activity director and was only an assistant. The AAD indicated the activity schedule was created by the Marketing director. The AAD indicated she would try to follow the calendar but some of the residents become tired easily and do not want to do activities as often as the calendar lists.</p> <p>During an interview with the Administrator on 7/17/15 at 1:30 p.m., the Adm indicated the facility did not have an Activity Director. The Adm indicated the Marketing Director was to have taken the class to become the Activity Director, but the Marketing Director had not completed the course. The Adm indicated the calendar is created by the Marketing Director.</p> <p>The facility lacked documentation of a policy regarding activities and an activity director.</p> <p>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</p>		<p>improvement process the administrator or designee will complete audits pertaining to the establishment of a functional activities calendar. Audits shall be completed monthly x 3, and quarterly thereafter. Any non-compliant practices will corrected immediately. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>following:</p> <p>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.</p> <p>(2) The resident ' s hospital preference.</p> <p>(3) The name and phone number of any legally authorized representative.</p> <p>(4) The name and phone number of the resident ' s physician of record.</p> <p>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</p> <p>(6) Information on any known allergies.</p> <p>(7) A photograph (for identification of the resident).</p> <p>(8) Copy of advance directives, if available.</p> <p>Based on interview and record review, the facility failed to maintain a current emergency information file for any of the residents which was accessible to the staff. The facility further failed to indicated the resident's sex on the medical record information sheet for 5 of 6 residents reviewed. This had the potential to affect 9 (nine) of 9 residents of the facility. (Resident #1, Resident #3, Resident #5, Resident #6, Resident #7)</p> <p>Findings include:</p> <p>During an interview on 7/15/15 at 8:45 a.m., LPN #1 indicated the facility did not have an emergency file for any of the residents.</p>	R 0356	<p>R 356</p> <p>The corrective action taken for those residents found to be affected by the alleged deficient practice include:</p> <p>The Emergency Information Files have been updated to include gender. The Resident Face Sheet has been revised to include ginder. The emergency files have been removed from the individual resident charts and placed in a 3 ring binder located in the medicine cart storage room to facilitate rapid removal in the event of an evacuation.</p> <p>Other residents that have the potential to</p>	08/14/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>During an interview on 7/15/15 at 9:00 a.m., the Adm (Administrator) indicated the facility did not have an emergency file. The Adm indicated each resident's chart had an emergency file in the back of the chart in a sleeve with the resident's information form, picture, and advanced directives in it. The Adm indicated the sleeve was located in the chart in case the resident needed to be transferred to the hospital immediately. Upon query, the Adm indicated he did not have the emergency information file immediately accessible for the staff.</p> <p>During the review of the resident information form, the form failed to list the resident gender for Resident #1, Resident #3, Resident #5, Resident #6, and Resident #7.</p> <p>During an interview on 7/15/15 at 3:50 p.m., the Adm indicated he did not realize the resident's gender was not listed on the resident's information form. The Adm further indicated the facility would need to be cited for this.</p> <p>A policy titled, "Emergency Information File," obtained from the Administrator on 7/17/15 at 1:05 p.m., indicated a current emergency information file shall be maintained for each resident and contain</p>		<p>be affected by the alleged deficient practice have been identified by: All residents had the potential to be affected The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include: The Policy and Procedure pertaining to the emergency file has been reviewed and revised noting the location at which the files will be maintained. Current staff has been personally instructed by the administrator as to the location of the files. New Employee Orientation procedures are being reviewed to assure the inclusion of training pertaining to the location of Resident Emergency Files. The corrective action taken to monitor performance to assure compliance through quality assurance is: As an ongoing quality improvement process the administrator or designee will complete audits pertaining to the completion of and proper location of the Resident</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
R 0410 Bldg. 00	<p>the resident's name, sex, room number, phone number, age or date of birth.</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction</p>		<p>Emergency Files. Audits shall be completed weekly x 4, monthly x2, quarterly thereafter. Any non-compliant practices will corrected immediately. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview the facility failed to ensure a TB (Tuberculin Skin Test) Step 1 and Step 2 was completed on admission for 2 of 6 residents reviewed. (Resident #5 and Resident #10)</p> <p>Findings include:</p> <p>1. On 7/14/15 at 3:00 p.m., during record review, the clinical record indicated Resident #5 was admitted on 6/8/15. The clinical record indicated the first step TB test was administered on 6/17/15. No second step test was found.</p> <p>On 7/15/15 at 9:35 a.m., during an interview, LPN #1 indicated she had looked for the second step which could not be found and indicated it had not been administered.</p> <p>2. A record review on Resident #10, on 7/15/15 at 2:00 p.m., indicated no Tuberculin testing had been done.</p> <p>The policy manual was obtained from the Administrator on 7/14/15 at 3:00 p.m. Review of the policy for Mantoux</p>	R 0410	<p>R 0410</p> <p>The corrective action taken for those residents found to be affected by the alleged deficient practice include:</p> <p>Resident # 10 was a closed record review. He was discharged prior to receiving the second step PPD. Policies and Procedures were reviewed and revised to be reflective current regulation in that it is only necessary to administer one (1) PPD if there is a documented negative tuberculin skin test during the preceding twelve (12) months for which resident # 5 had documentation of such. Therefore making a one step an acceptable practice.</p> <p>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</p> <p>All residents had the potential to be affected</p> <p>The measures or systematic changes that have been put into place to</p>	08/16/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	Testing, which was undated, indicated all assisted living residents will have a two step Mantoux upon admission.		<p>ensure that the alleged deficient practice does not recur include:</p> <p>Policies and Procedures were reviewed and revised to be reflective of current regulation in that a two step PPD is only necessary if there is not a documented negative tuberculin skin test result during the previous twelve (12) months. Appropriate staff will be inserviced on the policies and procedures pertaining to acceptable standards of practice pertaining to the tuberculin New Employee Orientation procedures are being reviewed to assure the inclusion of training pertaining tuberculin skin testing requirements.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>As an ongoing quality improvement process the administrator or designee will complete an audit during the preadmission screening process to assure compliancy of tuberculin skin testing practices. Audits will be completed as a</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2015
NAME OF PROVIDER OR SUPPLIER OASIS DEMENTIA CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
			<p>part of the preadmission screening process. Audit Summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive committee recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are necessary.</p>		