STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS AT 30TH	5651 E 30TH STREET, INDIANAPOLIS, , 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00365158, IN00365489, IN00363650, and IN00365664. Complaint IN00365158 - Substantiated. State Residential Findings related to the allegations are cited at R044. Complaint IN00363650 - Substantiated. State Residential Findings related to the allegations are cited at R154, R148, and R0041. Complaint IN00365489 - Substantiated. State Residential Findings related to the allegations are cited at R148, and R0041. Complaint IN00365664 - Substantiated. State Residential Findings related to the allegations are cited at R148, R0041 and R0154. Unrelated deficiency is cited.	R 0000		

	Survey dates: October 27, 28 and 2021 Facility number: 013347 Residential Census: 116 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 5, 2021			
R 0040	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(o)(1-3) (o) Residents have the right to form and participate in a resident council, and families of residents have the right to form a family council, to discuss alleged grievances, facility operation, residents ' rights, or other problems and to participate in the resolution of these matters as follows: (1) Participation is voluntary. (2) During resident or family council meetings, privacy shall be afforded to the extent practicable unless a member of the staff is invited by the resident council to be present. (3) The licensee shall provide space within the facility for meetings and assistance to residents or families who desire to attend meetings. Based on interview and record	R 0040	R040 – Residents' Rights Resident Council Corrective Actions for those residents found to have been affected: Regularly scheduled Resident Council meeting was conducted as displayed on the November Activity Calendar being the 3rd Wednesday of the month. Other residents having the potential to be affected will be identified and actions taken: All Residents have the potential to be affected. Resident Council resumed as scheduled. Corrective measures put into place:	11/17/2021

	review, the facility failed to ensure residents' were able to conduct monthly resident council meetings. This had a potential to affect 116 of 116 residents that reside at the facility. Findings include: The October 2021 activity calendar indicated resident council would meet on 10/20/21 at 2:00 p.m. A sign posted in the activities room was provided by the Activities Director on 10/28/21 at 12:53 p.m. It indicated "Attention Residents. Resident Council has been postponed, we will let you know asap when the rescheduled meeting will be held." An interview was conducted with Resident K on 10/27/21 at 12:10 p.m. She indicated resident council meetings were to be held on the 3rd Wednesday of each month. The past 2 months resident council meetings have been canceled by the Executive Director (ED). She had not heard when the meetings would be resumed. She would be moving out in November and was unaware who was taking over her position. An interview was conducted with the ED on 10/27/21 at 3:33 p.m. She indicated she had		Interpretation Services were scheduled ongoing for the 3rd Wednesday of each month to ensure Resident Council can be attended by all residents, including those with ASL needs. How corrective action will be monitored: E.D or designee will ensure that Resident Council is posted on Activity Calendar and carried out accordingly.	

	canceled the September resident council meeting, because she was unable to accommodate all residents in the facility that wanted to attend. A resident has stated she would like to attend, but needs an interpreter. The October resident council meeting was able to be held, but she had forgotten to remove the signage. The resident needing additional services was not in the building the scheduled day of the resident council meeting, so the other residents would have been able to have the meeting. The resident that needed services at that time uses pen and paper and a computer application to communicate. She was still trying to get an interpreter for the resident. An interview was conducted with Resident B on 10/27/21 at 3:45 p.m. He indicated he does not go to all the resident council meetings, but he does go to some. The residents had not been meeting in the last 2 months. An interview was conducted with the Activities Director on 10/28/21 at 12:33 p.m. She indicated she was new to the facility. She had started at the end of August. Resident Council meetings for September and October had been canceled by the ED due to a resident that			

	was needing an interpreter to attend the meetings. She was still learning the processes in the facility and unaware of how the appropriate department heads would be provided with the councils' suggestions and grievances once the meetings resumed. There was a box at the front management office that did have information on filing a grievance. The residents do want to continue to have monthly resident council meetings. During an interview with Resident E on 10/28/21 at 10:14 a.m. She would like to start going to the resident council meetings once they are resumed. Based on interview and record review, the facility failed to ensure residents' were able to conduct monthly resident council meetings. This had a potential to affect 116 of 116 residents that reside at the facility. Findings include: The October 2021 activity calendar indicated resident council would meet on 10/20/21 at 2:00 p.m. A sign posted in the activities room was provided by the Activities Director on 10/28/21 at 12:53 p.m. It indicated			

	"Attention Residents. Resident Council has been postponed, we will let you know asap when the rescheduled meeting will be held." An interview was conducted with Resident K on 10/27/21 at 12:10 p.m. She indicated resident council meetings were to be held on the 3rd Wednesday of each month. The past 2 months resident council meetings have been canceled by the Executive Director (ED). She had not heard when the meetings would be resumed. She would be moving out in November and was unaware who was taking over her position. An interview was conducted with the ED on 10/27/21 at 3:33 p.m. She indicated she had canceled the September resident council meeting, because she was unable to accommodate all residents in the facility that wanted to attend. A resident has stated she would like to attend, but needs an interpreter. The October resident council meeting was able to be held, but she had forgotten to remove the signage. The resident needing additional services was not in the building the scheduled day of the resident council meeting, so the other residents would have been able to have the meeting. The resident that			

	needed services at that time uses pen and paper and a computer application to communicate. She was still trying to get an interpreter for the resident. An interview was conducted with Resident B on 10/27/21 at 3:45 p.m. He indicated he does not go to all the resident council meetings, but he does go to some. The residents had not been meeting in the last 2 months. An interview was conducted with the Activities Director on 10/28/21 at 12:33 p.m. She indicated she was new to the facility. She had started at the end of August. Resident Council meetings for September and October had been canceled by the ED due to a resident that was needing an interpreter to attend the meetings. She was still learning the processes in the facility and unaware of how the appropriate department heads would be provided with the councils' suggestions and grievances once the meetings resumed. There was a box at the front management office that did have information on filing a grievance. The residents do want to continue to have monthly resident council meetings. During an interview with Resident E on 10/28/21 at 10:14			

	a.m. She would like to start going to the resident council meetings once they are resumed.			
R 0041	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(o)(4) (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on interview and record review, the facility failed to implement the facility's grievance policy to address, investigate and provide a resolution to a resident that has filed a grievance for 1 of 3 residents reviewed for grievances. (Resident E) Findings include: The "Resident Council Grievance Policy" was provided by the Executive Director on 10/27/21 at 11:00 a.m. It indicated, "All resident shall	R 0041	R041 Residents' Rights - Grievances Corrective Actions for those residents found to have been affected: Resident Grievances will be documented in the Resident Grievance Binder, and a solution or response will be communicated within 10 days and documented in the binder accordingly. Other residents having the potential to be affected will be identified and actions taken: All Residents have the potential to be affected. Corrective measures put into place: Staff to be educated on the Grievance Policy and Procedure to ensure all Resident Grievances reach the appropriate department leaders. How corrective action will be monitored: Audits of staff will be conducted to ensure education and compliance with the Resident Grievance	12/01/2021

	have the right to voice concerns and/or complaints which affect their lives at the facility without fear of discrimination or reprisal. Resident concerns and/or complaints should be presented to the appropriate management staff member. The appropriate department head will initiate the Resident Grievance Form. Once the Resident Grievance Form has been completed, it will be forwarded to the Administrator. The Administrator shall oversee and ensure that a comprehensive investigation of the matter is conducted, corrective action is taken, if necessary, and a report is provided to the Resident within 10 days of filing the complaint. If such action is not satisfactory to the affected Resident, the Regional Director of [name of corporation]., the management company of the facility, shall further investigate the issue and shall provide the Resident with a written report of his/her analysis and any corrective action taken. Such report shall be provided within 10 days of the date of the Administrator's report. If the concern and/or complaint still has not been resolved, the the Director of Operations or Chief Operating Officer (COO) shall convene a "Mediating Committee", consisting of at least three (3) the facility residents. This committee shall evaluate the issue in question and recommend a non-binding		Policy. Results of audits will be reviewed at Daily Stand Up to ensure compliance.	

resolution to the Resident and the facility management staff. The facility Administrator will be responsible for maintaining records pertaining to Resident Grievances filed within the facility. The Administrator will produce these records for review by the HFS staff when requested.

The September and October 2021 resident grievances that were filed were provided by the Executive Director (ED) on 10/27/21 at 12:00 p.m. The following grievances were provided:

A grievance dated 10/19/21 indicated Resident E was having some concerns with laundry being returned not clean and not returned timely.

A grievance dated 10/21/21 indicated Resident B had dignity and respect concerns in the dining room and billing.

A grievance dated 10/25/21 from Resident HH indicated, "...I have several concerns not just for myself but also my peers here. I have filed many grievances in the past, but nothing seems to happen. Like they just disappear..." The resident's grievance indicated concerns with dining and kitchen, missing items, dignity/respect.

All 3 of the residents' grievances

were within 10 days filed.

A confidential interview was conducted on 10/27/21 at 12:00 p.m. She indicated resident concerns are reported, but are not addressed.

During an confidential interview on 10/27/21 at 3:30 p.m., she indicated the facility does not address the residents' concerns. During visits to the facility, residents have approached her and expressed concerns they have had. They have indicated their concerns and/or grievances are not looked into or resolved. She has also requested to speak with the ED regarding concerns she has had and was told the ED was not available.

An interview was conducted with Resident B on 10/27/21 at 3:45 p.m. He indicated the facility does not address concerns that are brought to their attention. He reports at least 2 grievances a month. The 10/21/21, grievance form was the first grievance he has filed and received a copy of.

During an confidential interview on 10/28/21 at 9:30 a.m., indicated the residents report grievances all the time. The grievances are "ignored."

An interview was conducted with Resident E and Home Health Aide (HHA) 5 on

	10/28/21 at 10:14 a.m. Resident E indicated she has several concerns, and the facility are not addressing any of them. The grievance filed on 10/19/21, was the first time she had ever written a grievance, but not the first time she has reported a grievance about the laundry. She normally reports her grievances verbally. The grievances she has reported are not addressed. The laundry complaint has been and on going concern since admission. She was admitted about 6 months ago. Another concern she has had and reported was on 10/21/21, she had gone to the doctor for a blood draw. The nursing staff at the doctor office had placed a Band-Aid on her arm. After returning to the facility, she had removed the bandied on her arm. It began to bleed and would not stop. She went to the nurse's station and requested some help from nursing. She was told to go back to her room, and someone would be there in a minute. The resident went back to her apartment, and no one came to assist with the bleeding. She did have some coban bandages, so she wrapped her arm to stopped the bleeding. The next day she reported the concern to the Director of Nursing (DON) who provided care at that time to her arm. She never heard anything about the resolution to the staff not coming to her apartment			

	and assisting her when needed. It continues to happen. Resident E has also reported concerns regarding outside smoking activities. She would like to go outside and enjoy the outdoors, but unable to do so. The residents that smoke are suppose to go in the back of the facility or sit away from the front porch. The residents still continue to sit on the porch by the door and smoke. The ED has not addressed. HHA 5 indicated she provides care to the resident on a daily basis during the week. She has repeatly come in to the apartment, and the resident has been upset due to a concern that has not been addressed. HHA 5 has taken Resident E down to the front desk, so the resident can request to speak with the ED or DON about all the concerns the resident has. We are told to return to the apartment, and someone will be down. She had not seen a staff person come down to the apartment to discuss concerns with the resident after they have went to the front desk and requested. An interview was conducted with the ED and DON on 10/28/21 at 11:46 a.m. The DON indicated Resident E had reported the concern regarding her bleeding arm. It was looked into, and Qualified Medication Aide (QMA) 10 had spoken to			

	the resident regarding her arm that day. QMA 10 at that time was not working on the floor. She was in the building to do her in-service education and was unable to assist the resident. The DON had not filed a grievance for the care concern the resident had reported to her. The laundry concerns were currently being looked into that was filed on 10/19/21. The ED indicated the concern with the smoking activities was reported and being investigated. There was no grievance form filed about the concern. She was "policing" the front porch. All the residents should be 8 feet away from the door during smoking activity. This Residential Tag relates to Complaints IN00365489, IN00363650 and IN00365664. Based on interview and record review, the facility failed to implement the facility's grievance policy to address, investigate and provide a resolution to a resident that has filed a grievance for 1 of 3 residents reviewed for grievances. (Resident E) Findings include: The "Resident Council Grievance Policy" was provided by the Executive Director on 10/27/21 at 11:00 a.m. It indicated, "All resident shall			

	have the right to voice concerns and/or complaints which affect their lives at the facility without fear of discrimination or reprisal. Resident concerns and/or complaints should be presented to the appropriate management staff member. The appropriate department head will initiate the Resident Grievance Form. Once the Resident Grievance Form has been completed, it will be forwarded to the Administrator. The Administrator shall oversee and ensure that a comprehensive investigation of the matter is conducted, corrective action is taken, if necessary, and a report is provided to the Resident within 10 days of filing the complaint. If such action is not satisfactory to the affected Resident, the Regional Director of [name of corporation]., the management company of the facility, shall further investigate the issue and shall provide the Resident with a written report of his/her analysis and any corrective action taken. Such report shall be provided within 10 days of the date of the Administrator's report. If the concern and/or complaint still has not been resolved, the the Director of Operations or Chief Operating Officer (COO) shall convene a "Mediating Committee", consisting of at least three (3) the facility residents. This committee shall evaluate the issue in question and recommend a non-binding			

resolution to the Resident and the facility management staff. The facility Administrator will be responsible for maintaining records pertaining to Resident Grievances filed within the facility. The Administrator will produce these records for review by the HFS staff when requested.

The September and October 2021 resident grievances that were filed were provided by the Executive Director (ED) on 10/27/21 at 12:00 p.m. The following grievances were provided:

A grievance dated 10/19/21 indicated Resident E was having some concerns with laundry being returned not clean and not returned timely.

A grievance dated 10/21/21 indicated Resident B had dignity and respect concerns in the dining room and billing.

A grievance dated 10/25/21 from Resident HH indicated, "...I have several concerns not just for myself but also my peers here. I have filed many grievances in the past, but nothing seems to happen. Like they just disappear..." The resident's grievance indicated concerns with dining and kitchen, missing items, dignity/respect.

All 3 of the residents' grievances

were within 10 days filed.

A confidential interview was conducted on 10/27/21 at 12:00 p.m. She indicated resident concerns are reported, but are not addressed.

During an confidential interview on 10/27/21 at 3:30 p.m., she indicated the facility does not address the residents' concerns. During visits to the facility, residents have approached her and expressed concerns they have had. They have indicated their concerns and/or grievances are not looked into or resolved. She has also requested to speak with the ED regarding concerns she has had and was told the ED was not available.

An interview was conducted with Resident B on 10/27/21 at 3:45 p.m. He indicated the facility does not address concerns that are brought to their attention. He reports at least 2 grievances a month. The 10/21/21, grievance form was the first grievance he has filed and received a copy of.

During an confidential interview on 10/28/21 at 9:30 a.m., indicated the residents report grievances all the time. The grievances are "ignored."

An interview was conducted with Resident E and Home Health Aide (HHA) 5 on

	10/28/21 at 10:14 a.m. Resident E indicated she has several concerns, and the facility are not addressing any of them. The grievance filed on 10/19/21, was the first time she had ever written a grievance, but not the first time she has reported a grievance about the laundry. She normally reports her grievances verbally. The grievances she has reported are not addressed. The laundry complaint has been and on going concern since admission. She was admitted about 6 months ago. Another concern she has had and reported was on 10/21/21, she had gone to the doctor for a blood draw. The nursing staff at the doctor office had placed a Band-Aid on her arm. After returning to the facility, she had removed the bandied on her arm. It began to bleed and would not stop. She went to the nurse's station and requested some help from nursing. She was told to go back to her room, and someone would be there in a minute. The resident went back to her apartment, and no one came to assist with the bleeding. She did have some coban bandages, so she wrapped her arm to stopped the bleeding. The next day she reported the concern to the Director of Nursing (DON) who provided care at that time to her arm. She never heard anything about the resolution to the staff not coming to her apartment			

	and assisting her when needed. It continues to happen. Resident E has also reported concerns regarding outside smoking activities. She would like to go outside and enjoy the outdoors, but unable to do so. The residents that smoke are suppose to go in the back of the facility or sit away from the front porch. The residents still continue to sit on the porch by the door and smoke. The ED has not addressed. HHA 5 indicated she provides care to the resident on a daily basis during the week. She has repeatly come in to the apartment, and the resident has been upset due to a concern that has not been addressed. HHA 5 has taken Resident E down to the front desk, so the resident can request to speak with the ED or DON about all the concerns the resident has. We are told to return to the apartment, and someone will be down. She had not seen a staff person come down to the apartment to discuss concerns with the resident after they have went to the front desk and requested. An interview was conducted with the ED and DON on 10/28/21 at 11:46 a.m. The DON indicated Resident E had reported the concern regarding her bleeding arm. It was looked into, and Qualified Medication Aide (QMA) 10 had spoken to			

	the resident regarding her arm that day. QMA 10 at that time was not working on the floor. She was in the building to do her in-service education and was unable to assist the resident. The DON had not filed a grievance for the care concern the resident had reported to her. The laundry concerns were currently being looked into that was filed on 10/19/21. The ED indicated the concern with the smoking activities was reported and being investigated. There was no grievance form filed about the concern. She was "policing" the front porch. All the residents should be 8 feet away from the door during smoking activity. This Residential Tag relates to Complaints IN00365489, IN00363650 and IN00365664.			
R 0044	Residents' Right - Deficiency 410 IAC 16.2-5-1.2(r)(1-5) (r) The transfer and discharge rights of residents of a facility are as follows: (1) As used in this section, " interfacility transfer and discharge " means the movement of a resident to a bed outside of the licensed facility. (2) As used in this section, " intrafacility transfer " means the movement of a resident to a bed within the same licensed facility.	R 0044	RR044 Residents' Rights - Transfer and Discharge Corrective Actions for those residents found to have been affected: Provide all Residents leaving the facility with a copy of the facility Bed Hold Policy and Notice of Transfer of Discharge. Other residents having the potential to be affected will be identified and actions taken:	12/01/2021

	(3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: (A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or (F) the facility ceases to operate. (5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following: (A) The resident ' s physician when		All Residents have the potential to be affected. Corrective measures put into place: Staff will be educated on Bedhold/Transfer and Discharge Policy. How corrective action will be monitored: Audits of staff will be conducted to ensure education and compliance with the Bedhold/Transfer and Discharge Policy. Results of audits will be reviewed at Daily Stand Up to ensure compliance.	

transfer or discharge is necessary under subdivision (4)(A) or (4)(B).

(B) Any physician when transfer or discharge is necessary under subdivision (4)(D).

Based on interview and record review, the facility failed to issue and maintain a copy in the clinical record of a Notice of Transfer or Discharge for 3 of 3 residents reviewed for hospitalization. (Residents C, G, and H)

Findings include:

1. The clinical record for Resident C was reviewed on 10/28/21 at 10:15 a.m. The diagnoses included, but were not limited to, cancer.

The 6/1/21 progress note read, "Reporting Transition Out on June 01, 2021 at 12:00 pm, to Hospital/Admitted. Reason(s): Abnormal Vital Signs."

There was no Notice of Transfer or Discharge in Resident C's clinical record.

An interview was conducted with Family Member 3 on 10/28/21 at 10:40 a.m. She indicated when her father was ready to return to the facility after being released from the hospital and completing rehabilitation, the facility sent her an email on 6/24/21 informing her he was unable to

	return, and that she needed to come gather his belongings. Neither she nor her father was ever issued a Notice of Transfer or Discharge. Her father "was crying a lot about not being able to come back." On 10/28/21 at 3:04 p.m., Family Member 3 provided a copy of the 6/24/21 email sent to her by the facility's ED (Executive Director.) It read, "[Name of DON-Director of Nursing] and I visited [name of Resident C] at [name of skilled nursing facility] this afternoon while he was eating lunch. We were able to gather his progress notes and also spoke with the Therapy Department. Unfortunately after reviewing his prognosis and progress, the determination has been made that [name of Resident D] is not appropriate for Assisted Living and may not return to [name of facility.] Arrangements to pack and move his belongings need to be during normal business hours. Please let me know if you need anything else." The notice did not include an attached Notice of Transfer or Discharge. An interview was conducted with the DON in the presence of the ED on 10/28/21 at 12:38 p.m. She indicated Resident C was unable to return to the facility, because after speaking with his skilled nursing facility, it was revealed he had a history of			

	refusing trach care and was unable to provide his own trach care at the facility. Their process was to issue a Notice of Transfer or Discharge and bed hold policy to residents who went to the hospital, and keep a copy in their clinical record. Resident C's notice was either misplaced or never issued. 2. The clinical record for Resident G was reviewed on 10/28/21 at 11:14 a.m. The 8/2/21, 9:57 a.m. nurse's note read, "Resident sent out to ER [emergency room] on 7/30/21 for 02 sat [oxygen saturation] of 48%. NP [Nurse Practitioner] in facility and aware." The 9/8/21, 11:27 a.m. nurse's note read, "Spoke with resident's POA [power of attorney.] Per rehab [rehabilitation] facility, resident has plateaued in therapy and does not meet requirements for assisted living facility. Resident will be staying long tern in a snf [skilled nursing facility.]" There was no Notice of Transfer or Discharge in Resident G's clinical record.			

	An interview was conducted with the DON in the presence of the ED on 10/28/21 at 12:38 p.m. She indicated Resident G's notice was either misplaced or never issued. 3. The clinical record for Resident H was reviewed on 10/28/21 at 11:08 a.m. The 6/19/21, 12:52 p.m. nurse's note read, "Resident sent to [name of hospital] via EMS [emergency medical services.]" The 6/22/21, 1:00 p.m. nurse's note read, "Reporting Transition Out on June 22, 2021 at 01:00 pm, to SNF/NF [skilled nursing facility/nursing facility.] Reason(s): Other. Comments." There was no Notice of Transfer or Discharge in Resident H's clinical record. An interview was conducted with the DON in the presence of the ED (Executive Director) on 10/28/21 at 12:38 p.m. She indicated Resident H's notice was either misplaced or never issued.			

	An interview was conducted with the ED on 10/28/21 at 4:25 p.m. She indicated the facility had no policy on issuing a Notice of Transfer or Discharge. They didn't issue the notice for all residents who go to the hospital, only if it's determined the resident cannot return. This Residential Tag relates to Complaint IN00365158. Based on interview and record review, the facility failed to issue and maintain a copy in the clinical record of a Notice of Transfer or Discharge for 3 of 3 residents reviewed for hospitalization. (Residents C, G, and H) Findings include: 1. The clinical record for Resident C was reviewed on 10/28/21 at 10:15 a.m. The diagnoses included, but were not limited to, cancer. The 6/1/21 progress note read, "Reporting Transition Out on June 01, 2021 at 12:00 pm, to Hospital/Admitted. Reason(s): Abnormal Vital Signs." There was no Notice of Transfer or Discharge in Resident C's clinical record. An interview was conducted with Family Member 3 on 10/28/21 at 10:40 a.m. She indicated when her father was			

	ready to return to the facility after being released from the hospital and completing rehabilitation, the facility sent her an email on 6/24/21 informing her he was unable to return, and that she needed to come gather his belongings. Neither she nor her father was ever issued a Notice of Transfer or Discharge. Her father "was crying a lot about not being able to come back." On 10/28/21 at 3:04 p.m., Family Member 3 provided a copy of the 6/24/21 email sent to her by the facility's ED (Executive Director.) It read, "[Name of DON-Director of Nursing] and I visited [name of Resident C] at [name of skilled nursing facility] this afternoon while he was eating lunch. We were able to gather his progress notes and also spoke with the Therapy Department. Unfortunately after reviewing his prognosis and progress, the determination has been made that [name of Resident D] is not appropriate for Assisted Living and may not return to [name of facility.] Arrangements to pack and move his belongings need to be during normal business hours. Please let me know if you need anything else." The notice did not include an attached Notice of Transfer or Discharge. An interview was conducted with the DON in the presence of			

	the ED on 10/28/21 at 12:38 p.m. She indicated Resident C was unable to return to the facility, because after speaking with his skilled nursing facility, it was revealed he had a history of refusing trach care and was unable to provide his own trach care at the facility. Their process was to issue a Notice of Transfer or Discharge and bed hold policy to residents who went to the hospital, and keep a copy in their clinical record. Resident C's notice was either misplaced or never issued. 2. The clinical record for Resident G was reviewed on 10/28/21 at 11:14 a.m. The 8/2/21, 9:57 a.m. nurse's note read, "Resident sent out to ER [emergency room] on 7/30/21 for 02 sat [oxygen saturation] of 48%. NP [Nurse Practitioner] in facility and aware." The 9/8/21, 11:27 a.m. nurse's note read, "Spoke with resident's POA [power of attorney.] Per rehab [rehabilitation] facility, resident has plateaued in therapy and does not meet requirements for assisted living facility. Resident will be staying long tern in a snf [skilled nursing facility.]" There was no Notice of Transfer or Discharge in Resident G's clinical record.			

	An interview was conducted with the DON in the presence of the ED on 10/28/21 at 12:38 p.m. She indicated Resident G's notice was either misplaced or never issued. 3. The clinical record for Resident H was reviewed on 10/28/21 at 11:08 a.m. The 6/19/21, 12:52 p.m. nurse's note read, "Resident sent to [name of hospital] via EMS [emergency medical services.]" The 6/22/21, 1:00 p.m. nurse's note read, "Reporting Transition Out on June 22, 2021 at 01:00 pm, to SNF/NF [skilled nursing facility/nursing facility.] Reason(s): Other. Comments." There was no Notice of Transfer or Discharge in Resident H's clinical record. An interview was conducted with the DON in the presence of the ED (Executive Director) on 10/28/21 at 12:38 p.m. She indicated Resident H's notice was either misplaced or never issued.			

	An interview was conducted with the ED on 10/28/21 at 4:25 p.m. She indicated the facility had no policy on issuing a Notice of Transfer or Discharge. They didn't issue the notice for all residents who go to the hospital, only if it's determined the resident cannot return. This Residential Tag relates to Complaint IN00365158.			
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be	R 0148	R 148 Sanitation and Safety (building) Corrective Actions for those residents found to have been affected: Resident E's door handle remains on order and will be installed once it is received. Resident D's door handle to be installed as soon as it is received. Housekeeping has cleaned the vents and will continue with ongoing cleaning of vents weekly. All repairs have been made to Resident D's bathroom wall. Resident B's bathroom vent has been cleaned by housekeeping and will continue with cleaning of vents weekly. Ceiling paint and replacement flooring have been located in supply storage and will be installed prior to date of correction. Fire alarm cover replaced. Other residents having the potential to be affected will be identified and actions taken:	12/01/2021

	inspected. Based on observation and interview, the facility failed to ensure the facility and outside grounds were clean and free of garbage, and residents' rooms were in good repair for 3 of 3 residents rooms observed. (Resident B, D, and E) Findings include: During a confidential interview on 10/27/21 at 3:07 p.m., she indicated the facility was dirty. Resident D's room had needed repairs for several months and nothing had been done. The resident's door handle did not lock and mold was growing on the wall in the bathroom. 1. An observation was made of the facility on 10/27/21 at 10:27 a.m. The facility's flooring on the 1st, 2nd, 3rd and 4th floors, and the elevator flooring were observed with dirt and crumb debris along the corner edges and bottom floor trim. All the floor trim on each floor were dusty, and the 3rd floor had cob webs along the corner window. The hallway on the third floor had chucks of mud lying by the door. The staircase had a black and yellow substance dried on the flooring. The outside parking lot was observed with a torn black furniture cushion lying in a parking spot.		All Residents have the potential to be affected. Corrective measures put into place: Residents were educated on the proper procedure for reporting work orders during 11.17.2021 Resident Council to ensure all work order requests are received properly. MD will provide education regarding Housekeeping Weekly Duties and Schedule. How corrective action will be monitored MD to audit efficacy of housekeeping staff to ensure compliance and will report daily at Stand Up Meeting.	

	2. An observation was made of Resident D's room on 10/27/21 at 11:46 a.m. The door handle was observed. The bottom lock was unable to be locked. The door was able to be pushed open unless the inside top lock was engaged. The bathroom was observed with one wall that was unpainted with a white drywall mud stripe across it, and the ceiling vent was covered with a gray grime substance. An interview was conducted with Resident D on 10/27/21 at 11:50 a.m. She indicated the bathroom wall had been replaced approximately 2 weeks ago due to mold on the wall that had been for several months. The Maintenance Director (MD) had stated he would be back to paint the wall, but had not returned. The door knob was broken and had been like that for months. If the top bolt was not locked; the door would not stay closed and anyone in the hall was able to push the door open. She had been told a new handle had been ordered months ago. 3. An observation was made of Resident B's room on 10/27/21 at 3:45 p.m. The front entry ceiling was observed to have a water stain the length of the ceiling. The ceiling vent in the bathroom had a gray substance inside the cover, the fire alarm bottom cover was missing and			

	the flooring was not glued down. The resident indicated at that time the ceiling was due to the a sprinkler that went off months ago and the fire alarm had shorten out. The Maintenance department had gone through staff, and the repairs in the room had not been taken care of. 4. An observation was made of Resident E's room on 10/28/21 at 10:14 p.m. The inside door handle was raised and not sitting flush against the door. An interview was conducted with Resident E. She indicated the door lock had been broken, and the Maintenance Director had temporarily repaired. He had not been back to replace. The repair had been needed for awhile now and had not been addressed. The facility's floors in the hallways was dirty. She did not like to leave her apartment, because the debris on the flooring would get on her hands propelling herself with her wheelchair. An environmental tour was conducted with the Maintenance Director (MD) and the Executive Director (ED) on 10/28/21 at 2:00 p.m. The 2nd, 3rd and 4th floors and the elevators were observed to have crumbs and dirt debris on the corners and along the floor trim. The floor trim pieces were dusty and the window seal on the 3rd floor had cob webs along the corner. The			

	hallway flooring on the third floor had piles of mud on at one of the doors. The staircase had a black and yellow substance dried on the flooring. The outside parking lot was observed with a torn black furniture cushion lying in a parking spot in the road. The MD indicated he had not made his rounds outside to see the cushion that needed to be discarded. He indicated housekeeping did need to improve on the upkeep of the floors and the floor trim. The Ed indicated she had scrappers for the elevator flooring to remove the food and dirt debris in the the elevator floor. An observation was made of the stairwell with black and yellow substance on the floor. There also was a liquid substance pooled on the floor. The MD indicated at that time a resident in the facility urinates on the floor in the stairwell. The liquid puddle was urine. He would clean it up right away. During the tour, an observation was made of Resident E's door handle. The door handle was observed to be raised and not flush to the door. The MD indicated he was waiting for the door handle to come in. He had verbally ordered, but did not have a confirmation, or any documentation the door handle had been ordered. The supplier would call when the handle was			

	available. He could not recall when he had ordered the handle for Resident E's door. An observation was made of Resident D's room. The resident's door was able to be pushed open. The door handle's top lock was able to be engaged, but the bottom lock was unable to be locked. The wall was unpainted with a white drywall mud stripe across it, and the vent had a gray substance in it. The MD indicated at that time he had replaced the wall due to mold growing on it approximately a week to week in a half ago. Housekeeping should be cleaning the vents. Next week he was going to each resident's room and in putting in a log all repairs needed in each resident room. He had not been back in to Resident D's room to repair the wall. It would be painted tomorrow. He was able to go out to purchase a handle from a supplier for the resident's room tomorrow. An observation was made of Resident B's room. The resident's ceiling was observed with a water stained stripped across the ceiling, the bathroom ceiling vent had a gray substance inside it, the fire alarm had no bottom cover and the flooring was not glued to the floor. The ED indicated a sprinkler had went off and caused three resident rooms to			

	be damage in April 2021. She did have a bottom fire alarm cover in her office. The MD indicated the ceiling was ready to paint, and he was unaware of the flooring repairs that were needed in the resident's room. This Residential Tag relates to Complaints IN00365489, IN00363650 and IN00365664. Based on observation and interview, the facility failed to ensure the facility and outside grounds were clean and free of garbage, and residents' rooms were in good repair for 3 of 3 residents rooms observed. (Resident B, D, and E) Findings include: During a confidential interview on 10/27/21 at 3:07 p.m., she indicated the facility was dirty. Resident D's room had needed repairs for several months and nothing had been done. The resident's door handle did not lock and mold was growing on the wall in the bathroom. 1. An observation was made of the facility on 10/27/21 at 10:27 a.m. The facility's flooring on the 1st, 2nd, 3rd and 4th floors, and the elevator flooring were observed with dirt and crumb debris along the corner edges and bottom floor trim. All the floor trim on each floor were dusty, and the 3rd floor had cob webs along the corner window.			

	The hallway on the third floor had chucks of mud lying by the door. The staircase had a black and yellow substance dried on the flooring. The outside parking lot was observed with a torn black furniture cushion lying in a parking spot. 2. An observation was made of Resident D's room on 10/27/21 at 11:46 a.m. The door handle was observed. The bottom lock was unable to be locked. The door was able to be pushed open unless the inside top lock was engaged. The bathroom was observed with one wall that was unpainted with a white drywall mud stripe across it, and the ceiling vent was covered with a gray grime substance. An interview was conducted with Resident D on 10/27/21 at 11:50 a.m. She indicated the bathroom wall had been replaced approximately 2 weeks ago due to mold on the wall that had been for several months. The Maintenance Director (MD) had stated he would be back to paint the wall, but had not returned. The door knob was broken and had been like that for months. If the top bolt was not locked; the door would not stay closed and anyone in the hall was able to push the door open. She had been told a new handle had been ordered months ago.			

	3. An observation was made of Resident B's room on 10/27/21 at 3:45 p.m. The front entry ceiling was observed to have a water stain the length of the ceiling. The ceiling vent in the bathroom had a gray substance inside the cover, the fire alarm bottom cover was missing and the flooring was not glued down. The resident indicated at that time the ceiling was due to the a sprinkler that went off months ago and the fire alarm had shorten out. The Maintenance department had gone through staff, and the repairs in the room had not been taken care of. 4. An observation was made of Resident E's room on 10/28/21 at 10:14 p.m. The inside door handle was raised and not sitting flush against the door. An interview was conducted with Resident E. She indicated the door lock had been broken, and the Maintenance Director had temporarily repaired. He had not been back to replace. The repair had been needed for awhile now and had not been addressed. The facility's floors in the hallways was dirty. She did not like to leave her apartment, because the debris on the flooring would get on her hands propelling herself with her wheelchair. An environmental tour was conducted with the Maintenance Director (MD) and the Executive			

	Director (ED) on 10/28/21 at 2:00 p.m. The 2nd, 3rd and 4th floors and the elevators were observed to have crumbs and dirt debris on the corners and along the floor trim. The floor trim pieces were dusty and the window seal on the 3rd floor had cob webs along the corner. The hallway flooring on the third floor had piles of mud on at one of the doors. The staircase had a black and yellow substance dried on the flooring. The outside parking lot was observed with a torn black furniture cushion lying in a parking spot in the road. The MD indicated he had not made his rounds outside to see the cushion that needed to be discarded. He indicated housekeeping did need to improve on the upkeep of the floors and the floor trim. The Ed indicated she had scrappers for the elevator flooring to remove the food and dirt debris in the the elevator floor. An observation was made of the stairwell with black and yellow substance on the floor. There also was a liquid substance pooled on the floor. The MD indicated at that time a resident in the facility urinates on the floor in the stairwell. The liquid puddle was urine. He would clean it up right away. During the tour, an observation was made of Resident E's door handle. The door handle was			

observed to be raised and not flush to the door. The MD indicated he was waiting for the door handle to come in. He had verbally ordered, but did not have a confirmation, or any documentation the door handle had been ordered. The supplier would call when the handle was available. He could not recall when he had ordered the handle for Resident E's door.

An observation was made of Resident D's room. The resident's door was able to be pushed open. The door handle's top lock was able to be engaged, but the bottom lock was unable to be locked. The wall was unpainted with a white drywall mud stripe across it, and the vent had a gray substance in it. The MD indicated at that time he had replaced the wall due to mold growing on it approximately a week to week in a half ago. Housekeeping should be cleaning the vents. Next week he was going to each resident's room and in putting in a log all repairs needed in each resident room. He had not been back in to Resident D's room to repair the wall. It would be painted tomorrow. He was able to go out to purchase a handle from a supplier for the resident's room tomorrow.

An observation was made of Resident B's room. The resident's ceiling was observed

	with a water stained stripped across the ceiling, the bathroom ceiling vent had a gray substance inside it, the fire alarm had no bottom cover and the flooring was not glued to the floor. The ED indicated a sprinkler had went off and caused three resident rooms to be damage in April 2021. She did have a bottom fire alarm cover in her office. The MD indicated the ceiling was ready to paint, and he was unaware of the flooring repairs that were needed in the resident's room. This Residential Tag relates to Complaints IN00365489, IN00363650 and IN00365664.			
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (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. Based on observation, interview, and record review, the facility failed to maintain a clean kitchen and ensure hairnets were worn by staff in the kitchen. This had a potential to effect 116 of 116 residents that eat food prepared in the kitchen.	R 0154	R154 - Sanitation and Safety – (Kitchen) Corrective Actions for those residents found to have been affected: Soap Dispenser was remounted by handwashing sink, debris removed from floor, floor mopped. Dry storage area was swept and cleaned; floor drains emptied. Other residents having the potential to be affected will be identified and actions taken: All Residents have the potential to be affected.	12/01/2021

	Findings include: A confidential interview was conducted on 10/27/21 at 12:00 p.m. She indicated the kitchen was dirty, and the staff come and go in and out of kitchen without wearing hairnets. During a confidential interview on 10/27/21 at 3:07 p.m., she indicated the facility was dirty. A grievance form written by Resident HH dated 10/25/21 indicated the staff do not wear hairnets. An observation was made of the kitchen on 10/27/21 at 12:15 p.m. The kitchen flooring was observed with food debris scattered and sticky. A black box was observed on the floor of the dishwasher area. Cook 2 indicated it was the soap dispenser for the sink. It would not stay on the wall. The dry storage area was observed with food debris scattered along the back wall, condiment packages, and food wrappers. The drains in the floor were dirty with food debris. During the observation, Certified Nursing Assistant (CNA) 1 walked in from the dining room and was observed by the food prep area with no hairnet. Then the Activities Director entered the kitchen prep area and spoke to Cook 1. She did not place a hairnet on prior to walking into the kitchen		Corrective measures put into place: DM to educate staff on cleaning duties and ensure that cleaning log is filled out daily. Floor drain cleaning schedule changed to a daily cleaning event to ensure minimal buildup occurs. Education to all staff regarding hairnet usage in the kitchen food prep area to be provided. How corrective action will be monitored: DM to check cleaning logs daily as well as general cleanliness of the kitchen and report accordingly at Daily Stand Up Meeting.	

by the food serving area.

An observation was made of the kitchen with the Dietary Manager (DM) on 10/28/21 at 9:10 a.m. The kitchen food area was observed with Cook 3 preparing food in the prep area with a hairnet on. A long section of her hair that was blue in color was pulled out of the hairnet dangling above the food she was cutting in slices. An observation was made of food splattered all over the dishwasher area floor. Cook 1 indicated at that time food had come up from the drains and flooded all over the floor. The DM indicated the gray drain baskets were to be emptied every other day. The drains would clog with food debris causing a flood of water and food debris. An observation was made of one of the drains. Food debris was observed piled in the other plastic drain in the dishwashing area. A black soap dispenser was observed on the floor, and the dry storage area had food debris, food wrappers and condiment packages along the walls.

An interview was conducted with DM on 10/28/21 at 9:20 a.m. She indicated she currently has 4 cooks to assist in the kitchen. She has no dietary aides and has to utilize the nursing staff to assist with serving. Some nursing staff

	come to the dining room at meal times to assist and other times they do not. The habits of the few staff she does have either walk out and leave and/or call-in frequently. During those times she has been the cook and the server to the residents. The kitchen floor should be swept and mopped daily. There are daily cleaning logs to use, but the staff do not fill them out. She currently places posted notes on her door for kitchen cleaning duties for the staff to do. The DM was able to find a cleaning daily log dated March 2021. That was the last month the DM was able to locate the dietary staff had utilized daily cleaning logs. A "Kitchen Cleaning Frequency" policy was provided by the Executive Director on 10/28/21 at 2:04 p.m. It indicated "Procedure: The purpose of this policy is to ensure that kitchen equipment is being cleaned and there is no cross contamination. Policy: Is is the policy of this community to perform cleaning tasks to prevent foodborne pathogens...e) Non-food-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris. f) The approved [name of corporation] cleaning schedules shall be utilized. Task will be assigned on the				

Assignment Sheets for the Cooks and Dietary Aides."

This Residential Tag relates to Complaints IN00363650 and IN00365664.

Based on observation, interview, and record review, the facility failed to maintain a clean kitchen and ensure hairnets were worn by staff in the kitchen. This had a potential to effect 116 of 116 residents that eat food prepared in the kitchen.

Findings include:

A confidential interview was conducted on 10/27/21 at 12:00 p.m. She indicated the kitchen was dirty, and the staff come and go in and out of kitchen without wearing hairnets.

During a confidential interview on 10/27/21 at 3:07 p.m., she indicated the facility was dirty.

A grievance form written by Resident HH dated 10/25/21 indicated the staff do not wear hairnets.

An observation was made of the kitchen on 10/27/21 at 12:15 p.m. The kitchen flooring was observed with food debris scattered and sticky. A black box was observed on the floor of the dishwasher area. Cook 2 indicated it was the soap dispenser for the sink. It would not stay on the wall. The dry

storage area was observed with food debris scattered along the back wall, condiment packages, and food wrappers. The drains in the floor were dirty with food debris. During the observation, Certified Nursing Assistant (CNA) 1 walked in from the dining room and was observed by the food prep area with no hairnet. Then the Activities Director entered the kitchen prep area and spoke to Cook 1. She did not place a hairnet on prior to walking into the kitchen by the food serving area.

An observation was made of the kitchen with the Dietary Manager (DM) on 10/28/21 at 9:10 a.m. The kitchen food area was observed with Cook 3 preparing food in the prep area with a hairnet on. A long section of her hair that was blue in color was pulled out of the hairnet dangling above the food she was cutting in slices. An observation was made of food splattered all over the dishwasher area floor. Cook 1 indicated at that time food had come up from the drains and flooded all over the floor. The DM indicated the gray drain baskets were to be emptied every other day. The drains would clog with food debris causing a flood of water and food debris. An observation was made of one of the drains. Food debris was observed piled in the other plastic drain in the

dishwashing area. A black soap dispenser was observed on the floor, and the dry storage area had food debris, food wrappers and condiment packages along the walls.

An interview was conducted with DM on 10/28/21 at 9:20 a.m. She indicated she currently has 4 cooks to assist in the kitchen. She has no dietary aides and has to utilize the nursing staff to assist with serving. Some nursing staff come to the dining room at meal times to assist and other times they do not. The habits of the few staff she does have either walk out and leave and/or call-in frequently. During those times she has been the cook and the server to the residents. The kitchen floor should be swept and mopped daily. There are daily cleaning logs to use, but the staff do not fill them out. She currently places posted notes on her door for kitchen cleaning duties for the staff to do. The DM was able to find a cleaning daily log dated March 2021. That was the last month the DM was able to locate the dietary staff had utilized daily cleaning logs.

A "Kitchen Cleaning Frequency" policy was provided by the Executive Director on 10/28/21 at 2:04 p.m. It indicated "Procedure: The purpose of this policy is to ensure that kitchen

	equipment is being cleaned and there is no cross contamination. Policy: Is is the policy of this community to perform cleaning tasks to prevent foodborne pathogens...e) Non-food-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris. f) The approved [name of corporation] cleaning schedules shall be utilized. Task will be assigned on the Assignment Sheets for the Cooks and Dietary Aides." This Residential Tag relates to Complaints IN00363650 and IN00365664.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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