STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/07/2024

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 IN00444684, IN00437555, IN00436942, and IN00435620. Complaint IN00444684 - State deficiencies related to the allegation(s) are cited at R149. Complaint IN00437555 - No deficiencies related to the allegation(s) are cited. Complaint IN00436942 - No deficiencies related to the allegation(s) are cited. Complaint IN00435620 - No deficiencies related to the allegation(s) are cited. Survey Dates: October 4 and 7, 2024 Facility Number: 013347 Residential Census: 102	R 0000		

	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 9, 2024.			
R 0149	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(f) (f) The facility shall have a pest control program in operation in compliance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to timely follow pest control recommendations. This had the potential to affect 102 of 102 residents in the facility. Findings include: An interview was conducted with the Director of Nursing (DON) on 10/4/24 at 1:27 p.m. She indicated the facility had cockroach issues, mainly in the kitchen. They ended up shutting down the kitchen for a deep cleaning and treatment earlier that week and catered in two meals while the kitchen was shut down. On 10/4/24 at 2:14 p.m., an interview was conducted with the DON. She indicated the facility did not have a pest control policy, other than for bed	R 0149	Plan of Correction 10/14/24 Facility ID: 013347 Survey Event ID: PXXX11 R149 **1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a **2 How the facility will identify other residents having the potential to be affected by the same**	11/01/2024

bugs. She provided pest control logs for the past three months at that time.

The 7/11/24 log indicated Resident B's kitchen was filthy and had heavy roach activity behind the refrigerator. The room was treated and follow up was needed in two weeks. The log did not reference roach activity in any other apartments on the floor where Resident B resided. The log indicated the facility kitchen was very dirty, and roaches were found at the dishwasher.

The 7/18/24 log indicated Resident B's apartment was filthy with very heavy roach activity throughout. It was treated at that time but needed to be cleaned and prepared for further treatment. Follow up was needed in one week. The log did not reference roach activity in any other apartments on the floor where Resident B resided, and did not reference the facility kitchen.

The 7/25/24 log indicated Resident B's apartment was filthy with a heavy infestation of roach activity all over the apartment. It was treated at that time, but needed prepared for clean out and further treatment. Follow up was needed in one week. The log referenced two other apartments with roach activity on the floor where

deficient practice
and what corrective will be taken

a All residents had the potential to be
affected by the alleged deficient practice.
All managerial staff and line staff will monitor rooms for evidence of pest
infestation. Timely and prompt pest
control treatments will be scheduled accordingly.

3 What measures will be put into place
or what systemic changes the facility will make to ensure that the deficient
practice does not recur:

a Managerial staff and line staff will
monitor rooms for evidence of pest infestation.
A schedule has been put in place for all managerial staff to clean 10
rooms/week. Each shift and periodically,

	Resident B resided. One of the apartments was across the hall from Resident B's apartment. The 7/25/24 log did not reference the facility kitchen. There were no logs indicating follow up the following week to Resident B's apartment, as recommended in the 7/25/24 log. The next subsequent log was dated 8/15/24, three weeks later. The 8/15/24 log indicated Resident B's apartment was filthy with heavy roach activity throughout. It was treated at that time, but needed prepared for clean out and further treatment. Follow up was needed. The log indicated the facility kitchen was treated for roaches. The 8/22/24 log indicated Resident B's apartment was dirty with very heavy roach activity. It was treated at that time, "where possible." It read, "Needs prep [prepared] 5th attempt." Follow up was needed. The log did not reference the facility kitchen.		the rooms and designated areas will be checked for evidence of pest infestation. If pest infestation noted, timely and proper pest control maintenance will be scheduled for infected areas. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:**	

	The 8/29/24 log indicated Resident B's apartment was dirty and had roach activity. It was not treated at that time and read, "Will treat next week-needs prep." This log referenced roach activity in the apartment next door to Resident B's apartment. The log did not reference the facility kitchen. The 9/6/24 log indicated Resident B's apartment was dirty with very heavy roach activity in the kitchen. They treated where possible, but it needed prepared for clean out and further treatment. Follow up was needed in one week. The log did not reference the facility kitchen. The 9/12/24 log indicated roach activity in Resident B's apartment and read, "Needs clean out." It referenced roach activity in two other apartments on the floor where Resident B resided. The 9/19/24 log did not reference a visit to Resident B's apartment. It indicated the following areas had roach activity: kitchen, staff lounge, resident care area, back office, and two resident apartments. The 9/26/24 log did not reference a visit to Resident B's apartment. It indicated the back office, and three resident apartments had roach activity.		a Managerial staff and line staff will monitor rooms for evidence of pest infestation. A schedule has been put in place for all managerial staff to clean 10 rooms/week. Each shift and periodically, the rooms and designated areas will be checked for evidence of pest infestation. An in-service will be conducted for all staff to discuss monitoring of pest infestation and the room cleaning schedule no later than 10/21/24. Maintenance Director to review pest logs for recommendations after each visit. **5 By what date will the systematic changes be completed:** a Education and in-service will be provided to staff and residents between now and concluding on 11/01/24	

The three apartments were all on the same floor where Resident B resided. The log indicated the facility kitchen was dirty with heavy roach activity found throughout.

The 9/30/24 log indicated roach activity in Resident B's apartment as well as 3 other residents' apartments on the same floor as Resident B.

The 10/2/24 log indicated heavy roach infestation throughout the entire kitchen. The kitchen was fogged with treatment at that time.

The 10/3/24 log indicated Resident B's apartment was dirty and had heavy roach activity "all over," with 20-50 roaches found. It needed to be cleaned and prepared for further treatment. Follow up was needed in one week. The log indicated the staff lounge and six other resident apartments with roach activity, including four apartments on the same floor as Resident B.

On 10/4/24 at 11:47 a.m., an interview was conducted with the Pest Control Technician who documented the above 7/11/24 through 9/12/24 pest control logs. He indicated when the logs referenced preparing, it meant to empty things out, so they could get to the source of the pest activity. Resident B's room

was so severe with roach activity, that it needed to be prepared. He was able to spot treat Resident B's apartment, but no conventional clean out, also known as bombing, could be done unless the room was prepared. They made some progress with the spot treatments they did, but the last time he saw the apartment, approximately a month ago, it needed the conventional clean out, which hadn't yet been done. He'd spoken to the Regional Director of Maintenance to come up with a plan.

An interview was conducted with the Regional Director of Maintenance on 10/7/24 at 1:49 p.m. He indicated their pest control technician was going to come out next week with two to three people. They, along with management staff and housekeeping were going to prepare six to ten rooms a day for treatment, including Resident B's. He was unaware of the reason there was a delay in preparing Resident B's apartment for treatment, since the recommendation to do so had been made eight times since 7/18/24.

An observation of Resident B's apartment was made with Resident B on 10/7/24 at 2:39 p.m. The kitchen counters were dirty and cluttered, and there was a roach walking across the

	counter near the refrigerator. An observation of the kitchen was made with the CS (Culinary Specialist) on 10/4/24 at 1:45 p.m. The stove equipment was pulled out a foot from the wall. There were roach traps along the wall with five visible roaches trapped. The CS opened two of the stoves he indicated as not working. Upon closing the second stove door, one brown cockroach was observed walking on the floor in front of the stove. The CS stepped on it. There was a dead cockroach next to a piece of lettuce on the floor near the steam table. Another cockroach began moving quickly near the steam table. The CS stepped on it too. The dishwasher area along another wall had a roach trap with several roaches on it. The cooler was pulled out a foot from the wall. There were roach traps along the wall with at least twenty roaches on them. The CS indicated the dishwasher area was where most of the roaches were located. They did not have roach traps prior to two days ago, that he was aware of.			

An observation was made on 10/7/24 at 2:41 p.m. at the front desk to the facility. A staff member inquired with the receptionist regarding how to add the activity room to the "roach list," because a roach had fallen from the ceiling.

This deficiency relates to Complaint IN00444684.

Based on observation, interview, and record review, the facility failed to timely follow pest control recommendations. This had the potential to affect 102 of 102 residents in the facility.

Findings include:

An interview was conducted with the Director of Nursing (DON) on 10/4/24 at 1:27 p.m. She indicated the facility had cockroach issues, mainly in the kitchen. They ended up shutting down the kitchen for a deep cleaning and treatment earlier that week and catered in two meals while the kitchen was shut down.

On 10/4/24 at 2:14 p.m., an interview was conducted with the DON. She indicated the facility did not have a pest control policy, other than for bed bugs. She provided pest control logs for the past three months at that time.

The 7/11/24 log indicated

	Resident B's kitchen was filthy and had heavy roach activity behind the refrigerator. The room was treated and follow up was needed in two weeks. The log did not reference roach activity in any other apartments on the floor where Resident B resided. The log indicated the facility kitchen was very dirty, and roaches were found at the dishwasher. The 7/18/24 log indicated Resident B's apartment was filthy with very heavy roach activity throughout. It was treated at that time but needed to be cleaned and prepared for further treatment. Follow up was needed in one week. The log did not reference roach activity in any other apartments on the floor where Resident B resided, and did not reference the facility kitchen.			

	The 7/25/24 log indicated Resident B's apartment was filthy with a heavy infestation of roach activity all over the apartment. It was treated at that time, but needed prepared for clean out and further treatment. Follow up was needed in one week. The log referenced two other apartments with roach activity on the floor where Resident B resided. One of the apartments was across the hall from Resident B's apartment. The 7/25/24 log did not reference the facility kitchen. There were no logs indicating follow up the following week to Resident B's apartment, as recommended in the 7/25/24 log. The next subsequent log was dated 8/15/24, three weeks later. The 8/15/24 log indicated Resident B's apartment was filthy with heavy roach activity throughout. It was treated at that time, but needed prepared for clean out and further treatment. Follow up was needed. The log indicated the facility kitchen was treated for roaches.			

The 8/22/24 log indicated Resident B's apartment was dirty with very heavy roach activity. It was treated at that time, "where possible." It read, "Needs prep [prepared] 5th attempt." Follow up was needed. The log did not reference the facility kitchen.

The 8/29/24 log indicated Resident B's apartment was dirty and had roach activity. It was not treated at that time and read, "Will treat next week-needs prep." This log referenced roach activity in the apartment next door to Resident B's apartment. The log did not reference the facility kitchen.

The 9/6/24 log indicated Resident B's apartment was dirty with very heavy roach activity in the kitchen. They treated where possible, but it needed prepared for clean out and further treatment. Follow up was needed in one week. The log did not reference the facility kitchen.

The 9/12/24 log indicated roach activity in Resident B's apartment and read, "Needs clean out." It referenced roach activity in two other apartments on the floor where Resident B resided.

The 9/19/24 log did not reference a visit to Resident B's apartment. It indicated the

following areas had roach activity: kitchen, staff lounge, resident care area, back office, and two resident apartments.

The 9/26/24 log did not reference a visit to Resident B's apartment. It indicated the back office, and three resident apartments had roach activity. The three apartments were all on the same floor where Resident B resided. The log indicated the facility kitchen was dirty with heavy roach activity found throughout.

The 9/30/24 log indicated roach activity in Resident B's apartment as well as 3 other residents' apartments on the same floor as Resident B.

The 10/2/24 log indicated heavy roach infestation throughout the entire kitchen. The kitchen was fogged with treatment at that time.

The 10/3/24 log indicated Resident B's apartment was dirty and had heavy roach activity "all over," with 20-50 roaches found. It needed to be cleaned and prepared for further treatment. Follow up was needed in one week. The log indicated the staff lounge and six other resident apartments with roach activity, including four apartments on the same floor as Resident B.

On 10/4/24 at 11:47 a.m., an

interview was conducted with the Pest Control Technician who documented the above 7/11/24 through 9/12/24 pest control logs. He indicated when the logs referenced preparing, it meant to empty things out, so they could get to the source of the pest activity. Resident B's room was so severe with roach activity, that it needed to be prepared. He was able to spot treat Resident B's apartment, but no conventional clean out, also known as bombing, could be done unless the room was prepared. They made some progress with the spot treatments they did, but the last time he saw the apartment, approximately a month ago, it needed the conventional clean out, which hadn't yet been done. He'd spoken to the Regional Director of Maintenance to come up with a plan.

An interview was conducted with the Regional Director of Maintenance on 10/7/24 at 1:49 p.m. He indicated their pest control technician was going to come out next week with two to three people. They, along with management staff and housekeeping were going to prepare six to ten rooms a day for treatment, including Resident B's. He was unaware of the reason there was a delay in preparing Resident B's apartment for treatment, since the recommendation to do so

	had been made eight times since 7/18/24. An observation of Resident B's apartment was made with Resident B on 10/7/24 at 2:39 p.m. The kitchen counters were dirty and cluttered, and there was a roach walking across the counter near the refrigerator.			

An observation of the kitchen was made with the CS (Culinary Specialist) on 10/4/24 at 1:45 p.m. The stove equipment was pulled out a foot from the wall. There were roach traps along the wall with five visible roaches trapped. The CS opened two of the stoves he indicated as not working. Upon closing the second stove door, one brown cockroach was observed walking on the floor in front of the stove. The CS stepped on it. There was a dead cockroach next to a piece of lettuce on the floor near the steam table. Another cockroach began moving quickly near the steam table. The CS stepped on it too. The dishwasher area along another wall had a roach trap with several roaches on it. The cooler was pulled out a foot from the wall. There were roach traps along the wall with at least twenty roaches on them. The CS indicated the dishwasher area was where most of the roaches were located. They did not have roach traps prior to two days ago, that he was aware of.

An observation was made on 10/7/24 at 2:41 p.m. at the front desk to the facility. A staff member inquired with the receptionist regarding how to add the activity room to the "roach list," because a roach had fallen from the ceiling.

This deficiency relates to

	Complaint IN00444684.			

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