

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/08/2022	
NAME OF PROVIDER OR SUPPLIER OASIS ASSISTED LIVING, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE, EVANSVILLE, , 47714					
(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 Complaint IN00384300 and Complaint IN00391754. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00384300 - Substantiated. State deficiencies related to the allegations are cited at R0053. Complaint IN00391754- Substantiated. No deficiencies related to the allegations are cited. Survey dates: December 7, 8, 2022. Facility number: 013613 Residential Census: 61 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 16, 2022.	R 0000					

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			The Following Plan of Correction for Oasis Assisted Living regarding the statement of deficiencies dated December 08, 2022. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to the delivery of the best quality health care services and will continue to make changes and improvement to satisfy that objective. The facility is also requesting desk review for compliance in these areas.	
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to ensure resident's were free from	R 0053	The Following Plan of Correction for Oasis Assisted Living regarding the statement of deficiencies dated December 08, 2022. This plan of correction is not to be construed as an admission of or	12/29/2022

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FORM APPROVED

OMB NO. 0938-0391

abuse for 2 of 3 incidents reviewed. An employee physically abused a resident. (Resident J, Resident K)

Findings include:

1. On 12/7/22 at 9:25 a.m. during interview, QMA 1 indicated she had witnessed CNA 1 use an inappropriate approach to pull Resident J up and walk her to the cafe area, she had reported it.

On 12/7/22 at 12:15 p.m., a State Reportable was reviewed and indicated on 8/30/22 CNA 1 used an inappropriate tone of voice and approach with Resident J. The follow up to the investigation had a conclusion that CNA 1 utilized a substandard approach to Resident J,

resulting in termination of CNA 1.

An investigation summary dated 9/1/22 included, but was not limited to: " on 8/30/22 the administrator was notified of an incident on 8/30/22 in which a CAN (sic) was overheard using inappropriate tone of voice with a neighbor when attempting to get the neighbor to move from town square to the cafe' area for her evening meal. An investigation was initiated immediately. Upon assessing the resident bruising was identified on her wrist/fore arms

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Tag # R053

1.
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident J is no longer with the facility.
Resident K care plan has been updated to reflect interventions for staff to

(sic)...Upon reviewing the camera footage CAN (sic) [name] was viewed assisting the neighbor up from a lounge chair, ambulating to the cafe' area, and sitting in a chair to eat her meal. The footage shows inappropriate techniques utilized to assist the resident up from the lounge chair and into the dining chair..."

A statement by QMA 1 dated 8/31/22 was reviewed and included: " I witnessed [name] pull [name] up from chair in town square by the right hand/forearm Then guide her by the left arm towards the cafe area. [name] was saying "No, No" Then "you hurt me." [name] said "stop hurting me" [name] said "I hate you" [name] then said "I hate you too." ...

On 12/7/22 at 12:30 p.m., Resident J's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, anxiety, depression. Resident J no longer resided at the facility.

Nursing notes were reviewed and included, but were not limited to :

8/31/22 at 3: 26 p.m. "Bruises noted on left forearm and right forearm/hand. Reported to [name] LPN and Administrator. Investigation of injury of unknown injury started Daughter

utilize to ensure resident K remains calms and cooperative for all ADL care to ensure their psycho-social wellbeing and prevent future occurrences of inappropriate approach or words being utilized by staff when providing care.

2.
How will you identify other residents having potential to be affected by the same deficient practice?

All residents have the potential to be affected by the same deficient practice systematic changes are as follows: All staff will be trained on Abuse prevention and reporting upon hire and quarterly thereafter.

3.
What measures will be put into place or what systematic changes will make you to ensure the deficient practice does not recur?

All Employees will be informed upon hire

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notified. " 9/1/22 at 10:02 a.m., "X-ray OK'd by Dr.[name]. awaiting [name] to arrive." 9/1/22 3:43 p.m., " XRay to Left forearm" 9/1/22 4:16 p,m, " Resident refused Xray. Daughter notified suggested that a family member take her out for xray may be more cooperative with a family member. Daughter stated they did not get off work until after 3 and would not be able to get her in and out of the vehicle." 9/2/22 at 2:06 p.m., " Resident refused X-ray of left forearm this morning after numerous attempts. Family aware... Call received from Dr.[name] stating that resident needs to go to the ER to get X-ray of left forearm and UA [urinalysis] d/t resident's non-compliance." On 12/8/22 at 8:56 a.m. the Administrator indicated CNA 1 used an inappropriate approach with Resident J, she walked up and grabbed her by the wrist, should have used another staff to assist, grabbed her by the forearms and pulled her up one hand on waistband and one hand on her arm rushing her to the cafe area. The Administrator indicated X-rays were obtained after 3 attempts at the hospital and results were negative.	and trained at least quarterly thereafter of their responsibility to report immediately to their supervisor, actual and/or suspected incidents of resident mistreatment, neglect, physical, sexual, verbal, or mental abuse, or misappropriation of resident property to the Administrator or designee will be responsible for assuring that all alleged violations are thoroughly investigated, and the further potential abuse is prevented while an investigation is in process. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Administrator or designee will complete an audit of all abuse reports to ensure Abuse reporting Checklist of required documentation has been completed weekly for 30 days and then monthly for 6 months
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On 12/8/22 at 11:03 a.m., QMA 1 during interview indicated she witnessed CNA 1 grab Resident J by the arm, pull her from the chair, walk around and grab her by the other arm, the resident was saying " your hurting me", CNA 1 said she wasn't hurting her, Resident J told CNA 1 she hated her, and CNA 1 told Resident J she hated her too. QMA 1 observed swelling and bruising on Resident J's left arm the next day.

2. On 12/7/22 at 12:20 p.m., a State Reportable was reviewed and indicated CNA 2 was alleged by another employee to be rough while providing care. The incident date was 7/28/22. Follow up added on 8/2/22: Home Health aide is no longer employed...

An undated statement by Home Health Aide 1 included, but was not limited to, On Saturday July 23 rd 2022 between the hours of 4 am - 5 am I was working with CNA 2 [name]. She asked me "will you help me change [name resident K] because he shit himself"...[resident name] was slightly resistive to changing his clothes, which made [name CNA 2] aggravated (sic). She held out her hand [palm facing up] and [resident name] smacked her hand away but with ease, not enough force to hurt anyone. She then grabbed [resident name] by the

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shoulders/upper arms and started aggressively shaking him and yelling "you're not going to put your hands on me cause I'm going to hit back" Then she said " They already know I'm going to hit back". [name CNA 2] said she isn't dealing w/this and was going to get the nurse [name]...

On 12/8/22 at 9:45 a.m., Resident K's clinical record was reviewed. The diagnoses included, but were not limited to, frontal/temporal dementia w/behavioral disturbances, bipolar with psychotic features. Resident K was non interviewable upon attempt. No documentation was observed in the record regarding the alleged incident with CNA 2.

On 12/8/22 at 10:50 a.m., the Administrator indicated she nor the DON could find an incident report regarding the incident with CNA 2 and Resident K, the two nurses on duty the night of the incident no longer were employed at the facility, no documentation was found by the nurses on duty , no resident assessments on Resident K were found after the reported incident.

On 12/8/22 at 9:55 a.m., the current abuse policy was provided by the Administrator with a revision date of 11/16/18. The policy included, but was not

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limited to, The facility shall ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law. The incident actual incident should be reported to the Indiana State Department of Health within 24 hours of Clinical Nurse Leader being notified of incident...All employees will be informed, upon hire, and at least annually thereafter, of their responsibility to report immediately to their supervisor, or to facility administration in the absence of their supervisor, actual and/or suspected incidents of resident mistreatment, neglect, physical, sexual, verbal, or mental abuse, or misappropriation of resident property...The Director of Health Services or designee will be responsible for assuring that all alleged violations are thoroughly investigated, and that further potential abuse is prevented while an investigation is in progress...

This State Residential tag relates to Complaint IN00384300.

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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

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