STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS AT 56TH	4940 WEST 56TH STREET, INDIANAPOLIS, , 46254

(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 IN00364210 and IN00364686. Complaint IN00364210- Substantiated. State deficiencies related to the allegations are cited at R349 and R354. Complaint IN00364686 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 15, 2021 and October 18, 2021 Facility number: 14279 Residential Census: 106 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 26, 2021	R 0000	POC Complaint (IN00364210, IN00364686) October 18, 2021 I would respectively request a desk review.	

R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented for 3 of 3 residents who had accidents/incidents. (Residents B, D, and G) Findings include: 1. The clinical record for Resident B was reviewed on 10/15/21. Resident B's diagnoses included, but not limited to, major depressive disorder, epilepsy, and malignant neoplasm of kidney (cancerous tumor). Resident B moved into the facility on 9/20/21. An interview with Resident B was conducted on 10/15/21 at 11:40 a.m. She indicated, after she had moved into the facility,	R 0349	R349 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B, D, and G had their clinical record reviewed by DON and updated to reflect their service plan as needed. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All other residents had the potential to be affected by this deficient practice. All nursing staff was educated on 10/21/2021 by DON on documentation practices and the importance of maintain the residents clinical record to reflect the residents plan of care. -**What measures will be put into place or what systemic changes will be made to ensure that the**	11/07/2021

	she had boxes all over her room and it was difficult to move around in her room so she had stacked some of the boxes up so she could have a clear path. She stated, on one of the first weekends she had been at the facility, one of the stacks of boxes had fallen onto her and caused her shoulder and neck pain. Resident B went to the nurse on duty to report the occurrence and asked for an ice pack. She stated no one followed up with her the next day and so on the day after that, she called 911 to take her to the hospital. The clinical record for Resident B did not contain any documentation regarding Resident B's incident with boxes falling on her or notification of her physician. An interview with ED (Executive Director) was conducted on 10/15/21 at 3 p.m. She indicated, she believed it was 10/5/21 when Resident B was standing out in front of the facility and heard her yelling. ED stated she went out front to see Resident B and she stated that boxes fell on her and she was waiting for an ambulance. When ED asked if she was on phone with 911, the resident stated "no, I'm on the phone with the state". ED indicated, she thought the incident of the boxes falling on Resident B		**deficient practice does not recur?** DON/Designee will review the residents medical record after every accident/incident to ensure documentation and follow up has been noted in their medical record per policy and procedures. -**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.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed.	

	occurred on that same day and had no idea it had occurred on another day. 2. The clinical record for Resident D was reviewed on 10/18/21. Resident D's diagnoses included, but not limited to, major depressive disorder, atrial fibrillation, and chronic obstructive pulmonary disease. A nursing note dated 9/12/21 at 10:20 a.m. indicated, Resident D had no injuries from a fall that morning and nursing was "attempting to gain dau[sic, daughter's] phone number from resident,[sic] when we have it[sic] will call and notify dau[sic]". The clinical record did not indicate the resident's physician was notified of incident. A nursing note dated 9/23/21 at 10:41 a.m. indicated, "resident states she fell outside while smoking, states she was sitting on the window ledge and slipped off on her bottom, no injury noted, no redness to bottom or lower back. Vital signs taken. ROM[sic, range of motion] good in all extremities. Will notify family member". The clinical record did not indicate the resident's physician was notified of incident. 3. The clinical record for Resident G was reviewed on		At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered.	

	10/18/21. Resident G's diagnoses included, but not limited to, major depressive disorder, hepatitis B, and psychosis. A nursing note dated 10/1/21 at 1:19 a.m. indicated, "Resident was found on the floor at 12.23am[sic] during the wellness Check[sic], Resident said she fell from her wheel chair. Resident couldn't be lifted by the 2 aids, because she was too shaky and couldn't help herself. Resident was picked up from the floor by Non Emergency Department." The clinical record did not indicated Resident G's physician was notified of incident. A nursing note dated 10/3/21 at 6:51 a.m. indicated, "10-02-21 CNA[sic, certified nursing assistant] reported to Nurse[sic] Resident had someone call 911 r/t[sic, related to] not being able to breath[sic]. Nurse went to front doors wear[sic] location of Resident & '[sic]are located. Nurse gave information r/t [sic]resident history & EMT'S[sic, Emergency Medical Technician] took Resident to Hospital..." The clinical record did not indicated Resident G's physician was notified of incident. An interview with DON was conducted on 10/18/21 at 3:53 p.m. indicated, incident reports			

may not be in the electronic health record (EHR) related to the number of agency staff being utilized coupled with multiple steps to place it in the EHR.

A Incident Report policy was received on 10/15/21 at 1:30 p.m. from ED. It indicated, "Purpose: To ensure timely, complete reporting and appropriate follow-up of any occurrence involving a resident, staff member, family member, and/or visitor...B. Resident Related Incidents...3. Licensed nursing personnel will document resident accident/incident and follow-up as appropriate in the resident's progress notes including notification of the resident representative and attending physician. 4. Complete and enter the incident by completing the incident report in the electronic health record."

This state finding relates to Complaint IN00364210.

3.1-50(a)

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented for 3 of 3 residents who had accidents/incidents. (Residents B, D, and G)

Findings include:

	1. The clinical record for Resident B was reviewed on 10/15/21. Resident B's diagnoses included, but not limited to, major depressive disorder, epilepsy, and malignant neoplasm of kidney (cancerous tumor). Resident B moved into the facility on 9/20/21. An interview with Resident B was conducted on 10/15/21 at 11:40 a.m. She indicated, after she had moved into the facility, she had boxes all over her room and it was difficult to move around in her room so she had stacked some of the boxes up so she could have a clear path. She stated, on one of the first weekends she had been at the facility, one of the stacks of boxes had fallen onto her and caused her shoulder and neck pain. Resident B went to the nurse on duty to report the occurrence and asked for an ice pack. She stated no one followed up with her the next day and so on the day after that, she called 911 to take her to the hospital. The clinical record for Resident B did not contain any documentation regarding Resident B's incident with boxes falling on her or notification of her physician. An interview with ED (Executive Director) was conducted on			

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	states she fell outside while smoking, states she was sitting on the window ledge and slipped off on her bottom, no injury noted, no redness to bottom or lower back. Vital signs taken. ROM[sic, range of motion] good in all extremities. Will notify family member". The clinical record did not indicate the resident's physician was notified of incident. 3. The clinical record for Resident G was reviewed on 10/18/21. Resident G's diagnoses included, but not limited to, major depressive disorder, hepatitis B, and psychosis. A nursing note dated 10/1/21 at 1:19 a.m. indicated, "Resident was found on the floor at 12.23am[sic] during the wellness Check[sic], Resident said she fell from her wheel chair. Resident couldn't be lifted by the 2 aids, because she was too shaky and couldn't help herself. Resident was picked up from the floor by Non Emergency Department." The clinical record did not indicated Resident G's physician was notified of incident. A nursing note dated 10/3/21 at 6:51 a.m. indicated, "10-02-21 CNA[sic, certified nursing assistant] reported to Nurse[sic] Resident had someone call 911 r/t[sic, related to] not being able			

	to breath[sic]. Nurse went to front doors wear[sic] location of Resident & '[sic]are located. Nurse gave information r/t [sic]resident history & EMT'S[sic, Emergency Medical Technician] took Resident to Hospital..." The clinical record did not indicated Resident G's physician was notified of incident. An interview with DON was conducted on 10/18/21 at 3:53 p.m. indicated, incident reports may not be in the electronic health record (EHR) related to the number of agency staff being utilized coupled with multiple steps to place it in the EHR.			

	A Incident Report policy was received on 10/15/21 at 1:30 p.m. from ED. It indicated, "Purpose: To ensure timely, complete reporting and appropriate follow-up of any occurrence involving a resident, staff member, family member, and/or visitor...B. Resident Related Incidents...3. Licensed nursing personnel will document resident accident/incident and follow-up as appropriate in the resident's progress notes including notification of the resident representative and attending physician. 4. Complete and enter the incident by completing the incident report in the electronic health record." This state finding relates to Complaint IN00364210. 3.1-50(a)			
R 0354	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(g)(1-7) (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care	R 0354	R354 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff was educated on 10/21/2021 by DON on documentation practices and interfacility	11/07/2021

	facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview, the facility failed to utilize a interfacility transfer form for 1 of 3 residents reviewed for accidents/incidents. (Resident G) Findings include: The clinical record for Resident G was reviewed on 10/18/21. Resident G's diagnoses included, but not limited to, major depressive disorder, hepatitis B, and psychosis. A nursing note dated 10/3/21 at 6:51 a.m. indicated, "10-02-21 CNA[sic, certified nursing assistant] reported to Nurse[sic] Resident had someone call 911 r/t[sic, related to] not being able to breath[sic]. Nurse went to		transfer paperwork policy and procedures. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All other residents had the potential to be affected by this deficient practice. All nursing staff was educated on 10/21/2021 by DON on documentation practices interfacility transfer paperwork policy and procedures. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/Designee will review the residents medical record after every interfacility transfer to ensure documentation and follow up has been noted in their medical record per policy and procedures.	

	front doors wear[sic] location of Resident & '[sic]are located. Nurse gave information r/t [sic]resident history & EMT'S[sic, Emergency Medical Technician] took Resident to Hospital. ER[sic, emergency room] Doctor called needing MAR[sic, medication administration record] Nurse gave information r/t[sic, related to] MAR[sic]" Resident G's clinical record included an emergency printout. The information contained on the emergency printout for Resident G was: Resident G's name; facility's name, phone number and address; diagnoses list; and list of current medications. It did not contain the following items: name of receiving institution; resident's personal property; nursing notes relating to: resident's functional abilities and physical limitations, nursing care, treatment, current diet, and condition at transfer; presence or absence of decubitous ulcers; and date of chest x-ray and skin test for tuberculosis. An interview with DON (Director of Nursing) was conducted on 10/18/21 at 3:53 p.m. She indicated the facility does not utilize a transfer form when transferring a resident out of the facility but utilize the emergency printout.		-**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.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed**	

	This state finding relates to complaint IN00364210 3.1-50(h) Based on record review and interview, the facility failed to utilize a interfacility transfer form for 1 of 3 residents reviewed for accidents/incidents. (Resident G) Findings include: The clinical record for Resident G was reviewed on 10/18/21. Resident G's diagnoses included, but not limited to, major depressive disorder, hepatitis B, and psychosis. A nursing note dated 10/3/21 at 6:51 a.m. indicated, "10-02-21 CNA[sic, certified nursing assistant] reported to Nurse[sic] Resident had someone call 911 r/t[sic, related to] not being able to breath[sic]. Nurse went to front doors wear[sic] location of Resident & '[sic]are located. Nurse gave information r/t [sic]resident history & EMT'S[sic, Emergency Medical Technician] took Resident to Hospital. ER[sic, emergency room] Doctor called needing MAR[sic, medication administration record] Nurse gave information r/t[sic, related to] MAR[sic]" Resident G's clinical record included an emergency printout. The information contained on		November 6, 2021	

	the emergency printout for Resident G was: Resident G's name; facility's name, phone number and address; diagnoses list; and list of current medications. It did not contain the following items: name of receiving institution; resident's personal property; nursing notes relating to: resident's functional abilities and physical limitations, nursing care, treatment, current diet, and condition at transfer; presence or absence of decubitous ulcers; and date of chest x-ray and skin test for tuberculosis. An interview with DON (Director of Nursing) was conducted on 10/18/21 at 3:53 p.m. She indicated the facility does not utilize a transfer form when transferring a resident out of the facility but utilize the emergency printout. This state finding relates to complaint IN00364210 3.1-50(h)				

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