STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/02/2026

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 a State Residential Licensure Survey. This visit included the Investigation of Intakes 468024, 468402, and 468606. Intake 468024 - No deficiencies related to the allegations are cited. Intake 468402 - No deficiencies related to the allegations are cited. Intake 468606 - No deficiencies related to the allegations are cited. Survey dates: March 30, 31, and April 1, 2026. Facility number: 014279 Residential Census: 104 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5.	R 0000		

	Quality review completed on April 9, 2026.			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review the facility failed to	R 0092		04/20/2026

	conduct quarterly fire drills on the evening shift with the potential to affect 104 of 104 residents residing at the facility. Findings include: The fire drill logs for the second and fourth quarter of 2025 were reviewed on 4/1/26 at 5:10 p.m. The facility conducted fire drills as followed: 4/15/25 at 11:00 a.m., 5/10/25 at 7:05 a.m., 6/27/25 at 10:50 a.m., 10/28/25 at 10:50 a.m., 11/30/25 at 12:48 p.m., and 12/30/25 at 5:30 a.m. There was no documentation in the fire drill log of a drill being conducted on the evening shift in the second quarter and the fourth quarter of 2025. During an interview on 4/1/26 at 5:10 p.m., the Executive Director indicated that an evening shift fire drill had not been done in the second and fourth quarter of 2025.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and	R 0117		04/20/2026

	training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a staff person on every shift was first aide certified. This had a potential to affect 104 of 104 residents that resided in the facility. Findings include: The staff as worked schedule, dated 3/23/26 through 3/30/26, was provided by the Director of Nursing on 4/1/26 at 3:30 p.m. The schedule indicated the following days and shifts there were no staff members in the building that were first aide			

	certified: 3/23/26 - evening shift, 3/24/26 - evening and night shifts, 3/25/26 - evening shift, 3/26/26 - evening shift, 3/27/26 - evening shift, 3/28/26 - evening and night shifts, and 3/29/26 - day shift An interview was conducted with the Director of Nursing on 4/1/26 at 4:00 p.m. She indicated she was unable to provide any additional staff members in the building that were first aide certified.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on	R 0216		04/20/2026

admission and semiannually thereafter.

(4) If applicable, the resident ' s ability to self-administer medications.

(d) The evaluation shall be documented in writing and kept in the facility.

Based on observation, interview and record review, the facility failed to ensure self-mediation assessments were conducted biannually for residents that self-medicate and store medicines in their apartments for 2 of 5 residents observed during medication administration. (Resident 32 and Resident 52)

Findings include:

1. The clinical record for Resident 32 was reviewed on 3/31/26 at 12:05 p.m. The diagnosis included, but was not limited to, Schizophrenia (a mental disorder with loss of touch with reality).

A physician's order, dated 8/19/25, indicated Resident 32 was to receive 4 grams of diclofenac cream (anti-inflammatory drug) four times a day.

A self-medication assessment for Resident 32 was last assessed on 8/20/25. The

	resident's clinical record lacked a biannual self medication assessment to ensure the resident was able to continue to self-medicate and store diclofenac cream in her apartment. An observation of a medication administration was made for Resident 32 with License Practical Nurse (LPN) 5 on 3/31/26 at 12:19 p.m. LPN 5 was observed at the medication cart preparing for Resident 32's medication administration. LPN 5 pulled the diclofenac cream from the medication cart and entered the resident's apartment. The resident indicated she also had a tube and at that time pulled a tube of diclofenac cream from a table from her living room that she applies to her legs as needed. LPN 5 indicated she would return the diclofenac cream back to the medication cart, and the resident would use the diclofenac cream she had in her apartment. The resident indicated she had applied the cream herself to her left leg.			

	2. The clinical record for Resident 52 was reviewed on 3/30/26 at 2:05 p.m. The diagnosis included, but was not limited to, Chronic Obstructive Pulmonary Disease (COPD) (A lung disease that causes difficulty breathing). A self-medication assessment for Resident 52, dated 10/29/24, indicated no documented assessment on the form indiating if the resident was able to self medicate, and what medications and/or treatment he was able to self medicate. A physician's order, dated 10/24/25, indicated Resident 52 was to receive 3 milliliters of Ipratropium/albuterol nebulizer breathing treatments every 6 hours. An observation of a medication administration was made for Resident 52 with LPN 5 on 3/31/26 at 1:08 p.m. LPN 5 was observed pulling and preparing the resident's medication from the medication cart. She indicated Resident 52 stores his albuterol breathing treatments in his room. LPN 5 entered Resident 52's room, and the resident pulled a couple of vials of albuteral medication out from under the bed sheets. The resident indicated he likes to keep his breathing treatments in his bed for easily access when			

	he feels he needs to administer a breathing treatment. An interview was conducted with the Director of Nursing on 3/31/26 at 2:53 p.m. She indicated the residents that self medicate and store medications at the bedside should have self-medication assessments conducted.			

	A medication policy was provided by the Executive Director on 4/1/26 at 10:16 a.m. It indicated, " The purpose of this policy is to ensure that resident safety is maintained when managing, preparing, administrating, and storing all medications while complying with state and federal guidelines...Assessment: 1. The Director of Nursing, or licensed nurse designee, will assess the resident's ability to self-administer daily medications utilizing the Self-Medication Assessment. The assessment will determine what level of assistance, if any is needed by the resident. Medication set-up and storage protocol will be implemented based on the assessment outcome. The medication assessment will be reviewed biannually as part of the review process, and episodically with any significant change of condition or as level of service indicate..."			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. 2. The clinical record for	R 0240		04/20/2026

Resident 36 was reviewed on 3/31/26 at 10:45 a.m. The resident's diagnosis included, but was not limited to, diabetes.

A Level of Care Assessment, completed 3/2/26, indicated Resident 36 required caregivers to administer his medications.

A physician's order, dated 12/1/25, indicated Resident 36 was to receive prednisone (steroid medication) 20 milligram (mg) daily.

The March 2026 Medication Administration Record (MAR) indicated Resident 36's prednisone 20 mg was unavailable for administration on 20 days during the month.

During an interview on 3/31/25 at 3:10 p.m., the Director of Nursing indicated the prednisone had not been reordered. The nursing staff should have clarified if the prednisone needed a stop date.

3. The clinical record for Resident 107 was reviewed on 3/30/26 at 1:20 p.m. The resident's diagnosis included, but was not limited to, hypertension (high blood pressure).

During an interview on 3/30/26 at 1:20 p.m., Resident 107 indicated the facility staff administered his medications.

A physician's order, dated 5/5/25, indicated the resident was to receive metoprolol (heart medication) 50 mg twice daily. The metoprolol was to be held if Resident 107's systolic (top number of blood pressure reading) was less than 95.

The March 2026 MAR indicated Resident 107 had received metoprolol 50 mg twice daily. The resident's blood pressures were not recorded prior to the administration of the metoprolol.

During an interview on 3/31/26 at 3:10 p.m., the Director of Nursing indicated the blood pressure readings should have been documented in the clinical record to ensure the blood pressures were not out of range.

On 4/1/26 at 9:30 a.m., the Executive Director provided the Medication Management, Administration, and Storage Policy, last reviewed January 2025, that read "...B. Medication Administration: Medications administration will be administered as ordered by the resident's provider..."

Based on observation, interview and record review, the facility failed to ensure daily catheter

care was provided, daily cleaning of a respiratory BIPAP mask (a face mask that delivers high and low pressure air to assist with breathing), and that medications were administered as prescribed by the physician for 3 of 5 residents reviewed (Residents 36, 52, and 107).

Findings include:

1.The clinical record for Resident 52 was reviewed on 3/30/26 at 2:05 p.m. The resident's diagnosis included, but was not limited to, Chronic Obstructive Pulmonary Disease (COPD) (A lung disease that causes difficulty breathing).

A physician's order, dated 2/27/26, indicated staff was to provide BIPAP nightly. The staff were to clean the resident's face mask daily.

A physician's order, dated 3/3/26, indicated staff were to insert a indwelling urinary catheter. The facility staff and/or hospice staff were to provide daily catheter care.

Resident 52's clinical record did not include documentation staff were providing daily catheter care nor cleaning of the BIPAP face mask.

An interview was conducted with License Practical Nurse (LPN) 5 on 3/31/26 at 10:52

	a.m. She indicated Resident 52 has had a health decline and did not come out of his room very much any more. The facility staff did empty Resident 52's urinary catheter bag, but they did not provide catheter care. The hospice staff provided the catheter care to the resident. An interview was conducted with Resident 52 on 3/31/26 at 1:30 p.m. He indicated he was still recovering from an illness, but was getting stronger every day. The hospice aides came in twice a week, and the hospice nurse came in once a week. The facility staff did come in and empty his urinary catheter bag. He did most of the cleaning of the urinary catheter when he washed up in the bathroom sink. An interview was conducted with the Director of Nursing on 3/31/26 at 2:53 p.m. She indicated she was unable to provide documentation of daily catheter care and cleaning of the resident's BIPAP face mask were being provided as ordered.			

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