STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00401178, IN00405724, IN00406965 and IN00407210. Complaint IN00401178. State deficiency related to the allegations is cited at R0349. Complaint IN00405724. No deficiencies related to the allegations are cited. Complaint IN00406965. No deficiencies related to the allegations are cited. Complaint IN00407210. No deficiencies related to the allegations are cited. Survey dates: May 3 and 4, 2023 Facility number: 013347 Residential Census: 108 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on May 9, 2023	R 0000		
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brianna Kimbrough	RN, DON	05/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	(3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure detailed documentation reflected the care needs and services provided to 1 of 6 residents reviewed for care needs. (Resident G) Findings include: The clinical record of Resident G was reviewed on 5-4-23 at 11:45 a.m. Her diagnoses included, but were not limited to cerebral palsy, hypertension and atherosclerosis of the left lower extremity. Her most recent "Level of Service Assessment/Evaluation," dated 2-21-23, indicated she was oriented to person, place, and time, as well as was adequately oriented to function independently in familiar surroundings and able to make safe decisions in familiar situations. A review of a reportable incident from the facility to the Indiana Department of Health (IDOH), indicated on 5-4-23, Resident E reported an allegation of physical abuse in which Resident F struck Resident G with his hand in the dining area on 5-3-23. In a follow-up investigation, dated 5-4-23, this allegation was determined by the facility to be unsubstantiated. In an interview with the Administrator on 5-3-23 at 3:45 p.m., he indicated he had been made aware of a confrontation between Resident F and Resident G earlier that day which had occurred the previous day, 5-2-23. "In my investigation, no one made any mention of any physical contact, let alone her actually being struck by him. [Name of Resident F] was sent out to psych after that." He indicated when he had been aware of the incident, it was in terms of a verbal confrontation, but had "only received an allegation of physical abuse, as of	R 0349	Plan of Correction 05/23/2023 Facility ID: 013347 Survey Event ID: 3PTV11 R349 **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 deficient practice and what corrective will be taken** a. All residents requiring proper documentation of incidents, had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all QMAs and Nurses on properly documenting occurrences in real time in the EMR. Employees found to be out of compliance with properly documenting will receive additional education and possible corrective action. **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:**	05/23/2023

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	right now, from you as a result of your conversation with another resident." In an interview with Resident G on 5-4-23 at 1:40 p.m., with CNA 5 present at the resident's request, she indicated an incident with Resident F took place on 5-1-23 around 6:00 p.m., after dinner. She indicated Resident F was wanting her to clean up the dining tables. CNA 5 indicated Resident G is not physically able to do that type of thing. Resident G indicated Resident F did not touch her, but was verbally insistent she do what he told her to do. Resident G indicated staff were able to get Resident F away from her and keep her safe. Resident G indicated she does feel safe at the facility, but was frightened by Resident F at the time of the incident. In a review of the "Communication Log," also known as the nursing progress notes, there was no documentation of the above incident in Resident G's clinical record. The most recent documentation reflected a note, dated 4-12-23, regarding Resident G's need for a prescription for a wheelchair battery. The next entry, dated 5-4-23, indicated the facility spoke with a caseworker regarding getting a battery repair for Resident G's electric wheelchair. In a review of the "Communication Log," also known as the nursing progress notes, for Resident F, dated 5-2-23 at 12:07 p.m., and identified as a late entry for 5-1-23, a note indicated Resident F was "increasingly agitated and threatened physical harm towards other residents." In an interview with the Director of Nursing (DON) on 5-4-23 at 4:07 p.m., she indicated she was unsure why more documentation was not		a. An inservice will be held by the Director of Nursing for all QMAs and Nurses. Any clinical staff member out of compliance with facility's policies and protocols relating to documentation will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to proper documentation during employee job-specific orientation moving forward. **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:** a. The Director of Nursing or designee will audit documentation five (5) times per week for two (2) months, and as needed, then one (1) time a month for twelve (12) months, and then as needed to ensure that documentation is properly being entered into the EMR. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed** a. Education and in-service will	

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	done by the staff. She indicated she was unable to locate a specific policy relating to documentation for the facility. This Residential tag relates to Complaint IN00401178. 2.5-8.1(a)(1) 2.5-8.1(a)(2) 2.5-8.1(f)		be provided to all clinical staff on May 23rd, 2023	