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	02/29/2024

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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00426449, Complaint IN00429137, and Complaint IN00423700. Complaint IN00426449 - State deficiencies related to the allegations are cited at R0053, R0091, R0240 and 9999. Complaint IN00429137- State deficiencies related to the allegations are cited at R0041. Complaint IN00423700 - No deficiencies related to the allegations are cited. Survey dates: February 27, 28, and 29, 2024 Facility number: 013347 Residential Census: 108 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 14, 2024	R 0000		
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview and record review, the facility to ensure residents were provided a dignified existence for 6 of 9 residents reviewed for respect and dignity. (Confidential Interview 11, Resident T, Resident H, Resident K,	R 0029	R29- Residents Rights Deficiency- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents educated on Resident Rights and	05/01/2024

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

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	02/29/2024

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
	and Resident N) Findings include: During a Confidential Interview 21, they indicated Cook 15, Cook 16 and the DM are not friendly to the residents. The DM has developed a "I don't give a crap attitude." They have observed Cook 15 and Cook 16 speak very disrespectfully to the residents. Cook 15 has called residents' names such as "drunks and SOB (son of a b****)." 1. During a Confidential Interview 11, they indicated the Dietary Manger (DM) was rude and intimidating. She has an "I don't care attitude." They have observed the DM making statements to the residents, "If you don't like it then don't come to eat." They would never make any suggestions about food due to the DM not being friendly at all. 2. During an interview with Resident T on 2/29/24 at 4:15 p.m., she indicated Cook 15 was rude and not nice. He has called her an "old rag." 3. During an interview on 2/27/24 at 3:07 p.m., Resident H indicated that they had come down to the dining room to pick up a meal that had not been brought up to them. They were waiting for the meal and talking with another resident, when the DM came out of the kitchen and loudly told them that it had been over 5 days since they had COVID, and they did not need their meals brought to their room anymore. Resident H had been "mortified" that her medical condition had been announced a crossed the dining room and had stayed in her room for several days afterward because they had been so embarrassed. 4. On 2/28/24 at 12:10 p.m., Cook 15 was observed in the kitchen, standing at the end of the serving		Grievance Policy How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the deficient practice; Residents educated on Resident Rights and Grievance Policy Education: All staff inservice on resident rights (Interactive with abuse) HIPAA- Education Signage on kitchen door indicating: Staff only beyond this door Resident education re: resident Rights (Focus on abuse) Staff Education Resident Rights Resident education on the Grievance Policy and Procedure Staff education on the Grievance Policy and Procedure New Admission/Diet change/Room tray notification to DM and/or designee. Room tray duration determined by DON and/ or Designee **QA— Executive Director or Designee-Review Grievances Weekly x 3 months Biweekly x 2 months. (Note follow up within 10 days) then PRN thereafter if continued compliance is attained.**	

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	02/29/2024

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
	table looking out of the kitchen door. Resident M was coming to the kitchen door on his scooter. Cook 15 loudly told Resident M that he was not allowed to come in the kitchen and that Cook 15 had told Resident M that many times, could someone else tell him, because Resident M just wouldn't listen. 5. During an interview on 2/28/24 at 12:15 p.m., Resident N indicated that they felt as though they were treated like livestock while in the dining room because the tables were full of dirty dishes used by others and did not get cleaned before other residents sat down to eat. 6. During an interview on 2/28/24 at 2:38, Resident K indicated that the former Executive Director had told him that he was no longer allowed to go into the dining room due to Resident K's odor. Resident K had changed the seat on his walker and the odor was gone. Since then, when Resident K went to the dining room Resident M would tell him to "Get the F*** out of there". Resident M did not want Resident K in the dining room. When Resident K was speaking to other residents in the dining room Resident M would come up to him and start cursing at him and telling Resident K that he "stunk". Resident K and Resident M had gotten into an argument and Resident M had thrown 2 cups of red punch all over Resident K. Resident K had remained calm and reported Resident M to the current Executive Director. Resident K was staying in his room most of the time to avoid Resident M. When Resident K decided to go the dining room, Resident M sat a crossed the room and held up his 2 middle fingers and waved them at Resident K "flipping me off". Resident K felt harassed by Resident M.			

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	02/29/2024

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
	During an interview on 2/29/24 at 10:25 a.m., QMA (Qualified Medication Aide) 7 indicated that she had observed Resident M throw drinks in Resident K's face. QMA 7 had observed Resident M cursing at Resident K and telling him that he stunk. Resident M cursed at others often and staff had lengthy conversations about Resident M's cursing. During an interview with the Administrator on 2/29/24 at 4:02 p.m., he indicated he provides resident rights and abuse in-service training to the staff often. A "Resident Relations" policy was provided by the Administrator (ADM) on 2/28/24 at 3:20 p.m. It indicated "...Purpose: To assure that all employees are aware of what is expected of them when dealing with residents of the community. Policy: All residents will be treated as individuals with consideration, respect, and full recognition of his/her dignity. All employees are expected to relate to residents in this manner...Responsibility: A. It is the responsibility of the Administrator to make sure that all employees are aware of resident rights and resident relations and observing them...D. It is the responsibility of the employees to observe good relationships, as outlined in the resident's rights and resident relations with all residents in the community. E. It is the responsibility of the department heads or supervisors to thoroughly investigate all complaints involving resident relations on a timely basis. They are also responsible for initiating any disciplinary action as deemed necessary..." A "Resident Personal Rights Policy and Procedure" was provided by the ADM on 2/28/24 at 3:20 p.m. It indicated "...Each resident shall have the right to: 1. Be free from mental,			

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	02/29/2024

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
	emotional, social and physical abuse and neglect and exploitations...5. Have his or her privacy respected...14. Be treated at all times with courtesy, respect, and full recognition of personal dignity and individuality..."			
R 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on interview and record review, the facility failed to address and follow up on grievances voiced at resident council meetings for 1 of 2 resident council minutes reviewed, and ensure grievances voiced by residents were documented that included the concern; the action taken; resolution and follow up with the resident for 1 of 4 residents reviewed for grievances. (Resident T) Findings include: 1. During a Confidential Interview 11, they indicated the facility does not address concerns that are voiced during resident council meetings. An interview was conducted with Resident Council President on 2/28/24 at 12:09 p.m. He indicated during resident council meetings the most common topics discussed in the meetings was security for the building and receiving the facility's own bus. Currently, the facility has to borrow from another facility, and residents have	R 0041	R41- Resident Rights Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident education on the Grievance Policy and Procedure How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the deficient practice; Residents educated Grievance Policy Resident education on the Grievance Policy and Procedure (Duplicate R29) Staff education on the Grievance Policy and Procedure (Duplicate R29) Provide Information on	05/01/2024

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	02/29/2024

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
	had to miss appointments due the availability of a bus. January 2024 and February 2024 resident council minutes were provided by the Resident Council Secretary on 2/28/24 at 2:00 p.m. A 1/6/24 note before meeting indicated the following: "transportation is a big problem, rent is a problem, new people are talking about the rent is to high, resident are complaining about call lights, no one is answering, aides be on their phones, need some one here housekeeping on weekends to empty trash" A Resident Council note dated 1/17/24 indicated "Resident complaining about call lights no one answering the call lights in a timely manner. Aides be on their phones. Need some housekeeping here on the weekends to empty trash and small tasks. Resident Council Minutes dated 2/21/24 indicated resident council had complaints with rising rent, broken shower head, aides won't come into resident room due to cat, and resident need aide on weekends. An interview was conducted with the Administrator on 2/29/24 at 12:06 p.m. He indicated he does not have any grievances that are from the resident council meetings. There was a break in communication. 2. The clinical record for Resident T was reviewed on 2/28/24 at 3:30 p.m. The resident's diagnosis included, but was not limited to: Anxiety. An interview was conducted with Resident T on 2/28/24 at 4:15 p.m. She indicated approximately a week ago, she was awoken at 2:30 a.m. by Resident V intoxicated banging loudly and yelling to open the F***ing door. She was scared and didn't answer the door. She reported to the Administrator.		Medicaid Waiver covered transportation (Verida and WellTrans) Receptionist to assist with transportation coordination as needed Resident Council to turn concerns in to Executive Director or Department Manager ED to designate appropriate Department to address resident concerns. Responses to be prepared and presented prior to the following Resident Council Meeting **QA-Review Executive Director or designee- Resident Council Notes/ Responses monthly x 6 months then PRN thereafter if continued compliance is attained** **QA- Review of call light report 5 x weekly By DON or designee- Documented follow up on any calls over 10 minutes x 8 weeks then PRN thereafter if continued compliance is attained**	

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	02/29/2024

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
	An interview was conducted with the Administrator on 2/29/24 at 2:31 p.m. He indicated he did not have any grievances for Resident T. Resident T had voiced concerns about Resident V intoxicated a week ago knocking on her door around 2:30 a.m. He had spoken to Resident T, and he denied the incident. He receives multiple concerns by the residents. He does address the residents' concerns, but he does not always write all of them down. A grievance policy and procedure was provided by ED on 2/27/24 at 2:42 p.m. It read "...All residents shall have the right to voice concerns and/or complaints which affect their lives at the facility without fear of discrimination or reprisal. Resident concerns and/or complaints should be presented to the appropriate management staff member. The appropriate department head will initiate the Resident Grievance Form. Once the Resident Grievance Form has been completed, it will be forwarded to the Administrator. The Administrator shall oversee and ensure that a comprehensive investigation of the matter is conducted, corrective action is taken, if necessary, and a report is provided to the Resident within 10 days of filing the complaint. If such action is not satisfactory to the affected Resident, the Regional Director of Guardant Management Solutions., the management company of the facility, shall further investigate the issue and shall provide the Resident with a written report of his/her analysis and any corrective action taken. Such a report shall be provided within 10 days of the date of the Administrator's report...The facility Administrator will be responsible for maintaining records pertaining to Resident Grievances filed within the facility. The Administrator will produce these			

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	02/29/2024

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
	records for review by the HFS staff when requested..." This citation relates to Complaint IN00429137.			
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to protect the resident's right to be free of neglect by failing to secure services for a resident requiring wound care. This failure resulted in the resident being hospitalized for cellulits for 1 of 1 residents reviewed for wounds. (Resident J) Findings include: The clinical record for Resident J was reviewed on 2/28/24 at 3:30 p.m. His diagnoses included, but were not limited to: Chronic Obstructive Pulmonary Disease (COPD), prostate cancer and congestive heart failure. The resident's level of service assessment dated 1/23/24 indicated Resident J "understands information conveyed without difficulty." He was oriented to person, place and time and aware of his own needs. Resident J did not have any treatments. The resident's service plan dated 2/11/24 indicated [Resident J] agrees for the facility to coordinate all healthcare needs...Objectives: Facility staff will	R 0052	R052 **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 that have wounds and require wound care treatments had the potential to be affected by the alleged deficient practice. All wounds are to be evaluated weekly - DON and/or ADON to round once a week, lay eyes on wound, note the status, verify treatment, make notes, gather notes from home health agency and download into the EMAR.	05/01/2024

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	02/29/2024

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
	assist with all healthcare needs as they arise." The resident was independent with medication administrations. The service plan did not indicate the resident was needing services for his leg wounds. A wound list dated 2/27/24 was provided by the Administrator on 2/27/24 at 3:00 p.m., indicating Resident J had wounds. A physician order dated 1/30/24 indicated resident was to receive triple antibiotic ointment. "Apply to affected leg ulcer daily." The resident's clinical record did not include any additional wound treatment orders and/or wound consultations for his leg wounds. A random interview was conducted with two male residents in the common area on 2/28/24 at 3:15 p.m. They indicated Resident J had wound dressings on his legs that were not being changed. "Please help my friend. He needs someone to help him with his wounds." An observation was made of Resident J in his room on 2/28/24 at 3:20 p.m. The resident had kerlex dressings observed wrapped around both legs with a corner of another dressing underneath coming out of the bottom of the kerlex dressing of one of his legs. The kerlex dressing was white with yellow drainage substance coming through the dressing. The resident's skin outside of both legs and feet appeared to be dry, scaly and light red in color. Resident J indicated he had wounds on both legs. He had a wound appointment a month ago and was given orders to have wound dressing changes. He was unsure what type of wounds he did have and unsure how often the dressings needed to be changed. Resident J was		**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 DON and/or ADON or designee will round once a week, lay eyes on wound, note the status, verify treatment, make notes, gather notes from home health agency and download into the EMAR. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to wound treatment during employee job-specific orientation moving forward. All residents will be educated to alert Nursing to any new or worsening wounds. **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 DON and/or ADON or designee will round once a week, lay eyes on wound, note the status, verify treatment, make notes, gather notes from home health agency and download into the EMAR. Results to be reviewed at monthly QI meetings for 6 months and make further recommendations based off audit	

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	02/29/2024

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
	told by the staff they do not do wound dressings. They would be setting up home health for him to have the wound service. It still hasn't happened. As of today, the Director of Nursing (DON) told him earlier he would be down to do the dressings, but he had to eat first. The resident had went looking for DON, but was unable to find him. The DON told him he was working on getting someone to come in the facility to do the dressings. The dressings had not been changed since he left the wound consultation a month ago. In the past, a nurse that worked here would do the dressing changes for him periodically, but she no longer works here. "She told me it was their secret." At that time, he provided a bag that contained kerlex rolls, abdominal pads and white packets. The cream that had to be applied he believed was at nurse's station and some was in the bag. An observation was made of Resident J with the DON on 2/28/24 at 3:35 p.m. During the observation, the DON indicated they did not have a wound specialist in the building nor does staff provide wound dressing services. Currently, he was trying to set up wound services for the resident. At that time, the resident had reported to the DON the wound dressings had not been changed since his wound consultation a month ago. The DON indicated wound services should have been set up for him. He did not feel comfortable with changing the wound dressings. He recommended sending the resident to the emergency room to have the wound dressings changed. The resident agreed. An interview was conducted with Qualified Medication Aide (QMA) 7 on 2/29/24 at 10:25 a.m. She indicated the staff do not provide wound care treatments to the residents. Resident J's wound treatments were not being done. A couple of		results. **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 5-1-24.	

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	02/29/2024

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
	months ago, a lady came into the facility soliciting to use her home health services. Resident J had agreed to use her services for his wounds. She did not know the company's name. The agency would not approve to pay the lady for her services, so she stopped coming. The facility has also had another home health service, approximately a month ago come out and assess Resident J's wounds to see if they will pick up the wound services. She was unaware if this service was going to start doing his wound treatments. An interview was conducted with the DON on 2/29/24 at 11:36 a.m. He indicated he was unaware of the lady that use to come in to treat Resident J's wounds. He did have a service come out to assess Resident J's legs. He received a text last Friday, from the service(Staff Person 10) indicating she was unable to provide wound services to the resident. At that time, the DON contacted the Staff Person 10 by phone. She indicated she was unable to assess the resident's wounds on his legs. The resident had reported to her he did not have wound treatment supplies, so she did not remove the dressings on his legs. The resident's insurance was also out of network. She was unable to provide would treatment services. After the call, the DON indicated Staff Person 10 should have spoken to him while in the building about the assessment was unable to be conducted due to the wound treatment supplies not available. He was unaware of the assessment not done until the text message. It was difficult with getting any information and/or paperwork from the home health agencies. An interview was conducted with QMA 8 on 2/29/24 at 11:47 a.m. She indicated Resident J's wound treatments were not being done. The staff do not provide wound treatments. She provided			

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	02/29/2024

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
	approximately a month ago a list of all residents with wounds in the building to the DON. Resident J was on the list. An interview was conducted with the DON on 2/29/24 at 12:00 p.m. He indicated Resident J was admitted to the hospital on 2/28/24. The resident was admitted with a diagnosis of cellulitis. He was receiving antibiotics and dressing changes for his wounds. The DON reported he was unable to provide wound consultations for the resident's wounds, and he did not know what type of wounds the resident had prior to the hospitalization on 2/28/24. The abuse policy dated revised date 2/2021 indicated "...Residents of the community have the right to be free of abuse, neglect and financial exploitation. Staff members will conduct themselves in a manner that is respectful and courteous at all times. Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the community...Reporting It is the mandatory for staff members to report suspected incidents of abuse, neglect, and financial exploitation. Staff members are required to immediately report suspect behaviors to their Department Manager. Documentation will be initiated by the Department Manager at the time of the initial report. The Department Manager will immediately inform the Administrator. Once an allegation of abuse has been reported, the accused individual will be immediately removed from the community and suspended pending the outcome of the investigation. Investigation. The Department Manager along with the Administrator will investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the			

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	02/29/2024

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
	Department Manager and the Administrator. Documentation of the investigation will be maintained by the Administrator. The community will suspend staff involved in the incident pending provider investigation. It is required that the Administrator report the reported incident to the applicable APS [Adult Protective Services] or CPS [Child Protective Services] office. Additionally, DDARS [Division of Disability, Aging, and Rehabilitation Services], shall be notified of the incident on the prescribed incident reporting format approved by DDARS within the specified time frame. The community will submit a final report to DDARS that includes how the investigation was handled, final outcome, who was involved, and what steps are being taken to prevent this situation in the future..."			
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to ensure a resident was free of verbal abuse for 1 of 4 residents reviewed for abuse. (Resident M) Findings include: The clinical record for Resident M was reviewed on 2/28/24 at 10:30 a.m. His diagnoses included, but were not limited to: acute renal failure. The resident's level of service assessment dated 12/28/23 indicated Resident M "understands information conveyed without difficulty." He was oriented to person, place and time; aware of his own needs; does have behaviors with attitudes and disturbances.	R 0053	R0053- Residents Rights Deficiency- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;Residents educated on Resident Rights and Grievance Policy, Activity Director terminated. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the deficient practice; Residents educated on Resident Rights and Grievance Policy	05/01/2024

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	02/29/2024

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
	A reportable incident dated 2/8/24 indicated on 2/9/24 [Resident M] "reported to Executive Director on 2/9/24 at 3:00 p.m. that the staff member Activities Director (AD) used profanity while talking about him to other residents on the bus. Moreover, [Resident M] stated that he overheard AD talking about him before they left on an outing that day...Action taken: Investigation started and employee was contacted and suspended pending investigation. Follow up: 2/28/24 The initial verbal abuse investigation was unsubstantiated and the employee was brought back to work.; an employee witness changed or expanded her statement. The employee was suspended again pending a second investigation. The matter was reinvestigated and found to have merit. This was considered verbal abuse by the staff member resulting in termination of employment..." The investigation file was provided 2/29/24 at 1:24 p.m. It included, but was not limited to the following: The reportable incident to Indiana Department of Health, A written statement by Resident M, indicated "I heard [AD] say, "I can't stand that mother f*****,' When I was waiting outside the bus to be loaded on. I was standing next to [Qualified Medication Aide (QMA) 7] when I heard this, someone on the bus question [AD] and said who? 'that d*** [Resident M].' After I got on the bus, I told [AD] I don't appreciate you calling be (sic) a mother f***** and I'm going to [Administrator] about it as soon as we get back from Walmart." A written statement by Resident X indicated "I was getting on the bus and heard [Resident M]		Education: All staff inservice on resident rights (Interactive with abuse) HIPAA- Education Signage on kitchen door indicating: Staff only beyond this door Resident education re: resident Rights (Focus on abuse) Staff Education Resident Rights Resident education on the Grievance Policy and Procedure Staff education on the Grievance Policy and Procedure **QA— Executive Director or Designee-Review Grievances Weekly x 3 months Biweekly x 2 months. (Note follow up within 10 days) then PRN thereafter if continued compliance is attained.**	

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	02/29/2024

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
	talking loud outside the bus. I heard AD say 'I'm not going to keep letting these residents disrespect me.' Next, [AD] said I'm going to report this to the Executive Director (Administrator), and she left off the bus and went into the building." A written statement by QMA 7 indicated "I was coming from inside the building and saw [AD] putting [Resident D] on the bus. I ask her why she was putting [Resident D] on the bus instead of [Resident M]. [Resident M] said [QMA 7] that's what I've been trying to tell [AD]. AD said she told him to stop talking to her. She let go the controller and said [QMA 7] you do it! I then took [Resident D] off the chair lift. I was putting [Resident M] on the chair lift and I heard [AD] say something to [Resident M] once he got on the bus he went in the center and was talking to [AD]. I was putting [Resident D] on the chair lift and closing up the bus." A written statement by AD indicated, "On 2/8/24 (Thursday) we was going on our outing to Walmart. My bus driver had left to get the bus when she got there the other bus driver had left with the bus. So I had told our residents that we had a little problem with the bus. So while we was waiting on the bus for them to go ahead and eat lunch because it was getting late and we probably would not have time to stop to get something to eat. [Resident M] started cussing me out calling me a kinds of dumb a** and mother f**** so I walked away and went into the dining room with the rest of the residents. By this time my bus driver had called me and said she was on her back with the bus. I went to tell our, Administrator that our bus driver finally gotten the bus and to let him know that [Resident M] was out in the front and he had cussed me out about the outing. [The Administrator] said he needed to talk to him			

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	02/29/2024

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
	anyway, so he was going to address him cussing me out. (Remind you this isn't the first time that he have done this, He cussed me and my old bus driver out and she quit on me...So back to Thursday the residents had eaten their lunch and started heading for the but. I had one lady on the lift and I was helping her on the bus. I got her on. So I had another lady that had just got out of the hospital and she want to go...When I had [Resident D] on the lift our bus driver [QMA 7] was like put [Resident M] on first then put [Resident D] on the bus. So as I was letting [Resident D] on the lift the chord off the lift got wrapped around the handle so as I was letting her down the chord slipped out of my hand and the box accidentally hit her leg. I did mambo (sic) [mumble] under my breath and it was low MF [mother f*****) but it was because the box had slipped out of my hand and it hit her legs and that was the reason why she was in the hospital. So I had told her I was so sorry. I didn't know that was going to happen and she said she was ok. Now by this time [Resident M] had came around the bus calling all kinds dumb a** and stupid (MF) so I still didn't say anything to him I just got off the bus to talk to [the Administrator] again." An interview was conducted Resident M on 2/28/24 at 10:25 a.m. He indicated he was verbally abused by the AD a few weeks ago. He was outside waiting for the bus to go to Walmart. AD was assisting residents on the lift to put them on the bus. While waiting, QMA 7 told AD to put him on first because his scooter was more smaller than the electric wheelchairs. He did voice at that time to QMA 7, "Yea, probably right. She didn't think to put me next." After his comment and the suggestion from QMA 7, the AD went into a "rage." She did not like the comment he had made and the suggestion QMA 7 had made. AD threw			

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	02/29/2024

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
	the remote to the lift on the ground and stated to QMA 7, "put him on yourself." She then got into the bus. QMA 7 picked up the remote and Resident M could clearly hear AD making statements on the bus. She said, "I can't stand that mother f*****. It was loud. One of the residents already on the bus said "who are you taking about?" She responded, "That d*** [Resident M], I can't stand his a**." After being lifted on the bus, I confronted AD. I stated, "I do not appreciate being called a MF. I am going to [Administrator]" after returning from the outing. AD got out of the bus and went into the facility right after. He was unable to go in with her due to already being lifted on the bus. She went into the facility and spoke to the Administrator. She told a lie. She told the Administrator he was the one that was cussing her out before he had gotten on the bus. That was not true. He did not cuss her out. The other residents on the bus protected her, because they are her "groupies." "They will not speak out about her." AD returned to the bus, and we left for the outing. There was no other incident that day, but he felt very upset. The other residents and the AD were laughing and giggling like nothing happened during the outing. He felt like someone "slapped him in the face." At first, the Administrator told me he had to have proof of what Resident M said happened. "I couldn't believe no one would "back me up." He later was told by the Administrator the AD was terminated. During a Confidential Interview 11, they indicated Resident M cusses out residents and staff. They did overhear the AD call Resident M a MF while going on an outing a few weeks ago. An interview was conducted with QMA 7 on 2/29/24 at 10:25 a.m. She indicated she works nursing and was also the bus driver for outings.			

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	02/29/2024

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
	She had went to pick up the bus at the other facility, and it was not available when she arrived. During the time, Resident M had gotten upset cussing at AD about the delay. Resident M cusses at residents and staff often. When she returned with the bus, AD was assisting Resident D onto the bus. She had suggested to put Resident M on the bus first due to it was smaller than the electric wheelchairs. Resident M stated he was trying to tell AD the same thing. She got upset about it. She gave me the remote. QMA 7 assisted Resident M on the bus utilizing the lift. QMA 7 did hear AD say MF and [Resident M]'s name. She did not hear enough of what was said to determine what context it was used. After Resident M was on the bus, she continued to assist other residents on the bus. Resident M and AD were heard arguing back-n-forth on the bus at that time. QMA 7 then heard AD state, "he aint talking to me like that." She had exited the bus and went inside. After, QMA 7 went inside the facility and found AD speaking to the Administrator. She was very upset at the time about Resident M. QMA 7 had indicated to AD to calm down and "just let it go." The Administrator had asked QMA 7 what she had heard. She reported she heard AD use the words MF and Resident M's name, but did not hear enough to determine the context. During and interview with the Administrator on 2/29/24 at 12:06 p.m. He indicated he had not spoken to Resident M until after he had returned from the outing. After the investigation was completed, it was determined the AD had verbally abused Resident M, and she was terminated. The abuse policy dated revised date 2/2021 indicated "...Residents of the community have the right to be free of abuse, neglect and financial			

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	02/29/2024

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
	exploitation. Staff members will conduct themselves in a manner that is respectful and courteous at all times. Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the community...Reporting It is the mandatory for staff members to report suspected incidents of abuse, neglect, and financial exploitation. Staff members are required to immediately report suspect behaviors to their Department Manager. Documentation will be initiated by the Department Manager at the time of the initial report. The Department Manager will immediately inform the Administrator. Once an allegation of abuse has been reported, the accused individual will be immediately removed from the community and suspended pending the outcome of the investigation. Investigation. The Department Manager along with the Administrator will investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the Department Manager and the Administrator. Documentation of the investigation will be maintained by the Administrator. The community will suspend staff involved in the incident pending provider investigation. It is required that the Administrator report the reported incident to the applicable APS [Adult Protective Services] or CPS [Child Protective Services] office. Additionally, DDARS [Division of Disability, Aging, and Rehabilitation Services], shall be notified of the incident on the prescribed incident reporting format approved by DDARS within the specified time frame. The community will submit a final report to DDARS that includes how the investigation was handled, final outcome, who was involved, and what steps are being taken to prevent this situation in the future..."			

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	02/29/2024

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
	This citation relates to Complaint IN00426449.			
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.			
	Based on interview and record review, the facility failed to maintain complete documentation of an abuse investigation, failed to ensure the facility developed an abuse policy that included reporting allegations of abuse to the Indiana Department of Health (IDOH) ,and thoroughly investigating an allegation of abuse for 2 of 4 residents reviewed for abuse and for 1 of 2 closed records reviewed. (Resident L, Resident D, and Resident W) Findings include: 1. On 2/27/23 at 3:30 p.m., the Administrator provided the 1/18/24 incident report for Resident L. It read, "At approximately 1:45 AM staff called and reported that [name of Resident L] was physically assaulted by a visitor in her room. The visitor also took [name of Resident L's] phone and keys and locked her in the resident's closet. Resident was able to escape out of her closet and reported the incident to nursing staff."The type of injury was a hematoma to her forehead, a contusion to her left outer eye and under her left eye. The immediate action taken was that Resident L was immediately assessed and examined by	R 0091	R91-Administration and Management Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident education re: resident Rights (Focus on abuse) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the deficient practice; Residents educated Resident Rights (Focus on Abuse) All allegations of abuse will be reported to ISDH within 24 hours and thoroughly investigated with a follow up within 5 business days Caremerge audited daily for reportable occurrences **QA-Review Caremerge notes for possible reportable**	05/01/2024

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	02/29/2024

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
	nursing staff for injuries, and the police wee immediately called. Resident L was also sent to the hospital for further evaluation. Preventive measures taken were that her entry door lock would be changed, and staff would be on the look out for the visitor in question and were alerted to call the police if this person was identified in the building. The follow-up section of the incident report was not completed. The 1/18/24, 6:48 a.m. nurse's note, written by LPN (Licensed Practical Nurse) 6, read, "Critical Reporting altercation. Resident came to nursing office at 12:30 AM, reporting she was beat up by her visitor in her room, Resident stated assailant was a female she refers to as her grand daughter, she stated she was hit about thee face and head, kicked in her rt [right] back side and shoved in her closet in her bedroom, and her bed was pushed up against door to lock her in closet, she reports assailant took her phone and her keys to her apartment. Resident has hematoma to forehead, contusion to lt [left] outer eye, and under left eye, she has some redness to neck, she states assailant attempted to choke her. Police was [sic] called. Incident report made, resident sent to hospital for evaluation. DON [name of DON] notified at 12:30 AM. Resident V/S [vital signs] 161/80-99-20-98.2 (T-temperature). Resident alert and responsive to all stimuli during interviews." The 1/18/24, 7:07 a.m. nurse's note read, "Resident returned to facility at 6:00AM, alert and responsive to all stimuli. Discharge paperwork received." The 1/19/24, 3:20 a.m. nurse's note read, "Resident has remained in her room at this time. She has voiced no complaints of discomfort r/t [related to] her incident. Continues to have discoloration to		**occurrences and proper follow up weekly x 8 weeks then monthly thereafter x 2 months then PRN thereafter if continued compliance is attained**	

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	02/29/2024

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
	left outer eye, and under left eye, decrease in size of hematoma on forehead. Resident is up ad lib in her room, independent for all ADL's [activities of daily living,] transfers. Will use call light for assist as needed. Will continue to monitor." An interview was conducted with the Administrator on 2/28/24 at 1:49 p.m. He indicated there was no investigative file for the 1/18/24 incident report involving Resident L. The information regarding the investigation was in her nursing notes. Resident L was assaulted and robbed by someone she knew. They took her cell phone and keys. Law enforcement was called, and he had an information card from them. Initially, Resident L did not provide the name of the person that assaulted and robbed her. Resident L admitted to drinking alcohol and smoking cigarettes during the incident. When he interviewed Resident L, he asked her about smoking, because the police said there was evidence of smoking in the room, and Resident L admitted to smoking in the room. The Administrator reminded Resident L smoking in her room was a violation of her lease. Resident L ended up discharging home on 2/12/24. He thought Resident L later provided the name of the perpetrator to the police, but never gave it to the facility. The police came back to the facility several times to speak with Resident L. There were concerns of the visitor coming back to the facility. They changed the locks to Resident L's apartment. The facility was "on lockdown" for a week. No one could come in the front door without someone letting them inside, as a precautionary measure. To his knowledge, the perpetrator never came back to the facility. He didn't know when the visitor arrived at the facility or how long they were there, just that Resident L wanted to protect the person, because she			

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	02/29/2024

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
	wouldn't provide the name at first. Normally, he would document everything associated with the investigation, but he had multiple things going on at the time. There was no documentation of his interview with Resident L, his interview with the police, or his interview with staff who first saw her after the incident. There was no documentation of the facility being on lockdown for a week afterwards, the police coming back to the facility several times, or hospital notes from her visit afterwards. The Administrator indicated he was going to look for the hospital notes. During an interview with the Administrator on 2/29/24 at 10:37 a.m., he indicated they had the hospital notes at one point, but was unable to locate them now. He just created a file for the investigation into the 1/18/24 reportable involving Resident L, which included a summary of what happened, the police information card, nurses notes, the reportable, and a 2/4/24 notice to residents regarding the facility's smoking policy. 2. The clinical record for Resident D was reviewed on 2/27/24 at 2:29 p.m. The resident's diagnosis included, but was not limited to: multiple sclerosis. The clinical record for Resident W was reviewed on 2/28/24 at 1:30 p.m. The resident's diagnosis included, but was not limited to: Parkinson's Disease. A reportable incident indicated on 11/21/23 Resident D "accused staff member [Certified Nursing Aide (CNA) 17] of purposely not serving her in the dining room and having an inappropriate sexual relationship with another resident [Resident W]...11/21/23 Investigation was started and the employee [CNA 17] was suspended pending investigation...Follow up: 11/25/23 After interviewing the employee and			

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	02/29/2024

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
	other residents during the investigation this accusation of ignoring a resident and sexual misconduct with another resident was unsubstantiated. The employee that was suspended came back to work on 11/23/23. This employee will receive customer service training to improve work performance." The investigation file was provided on 2/29/24 at 1:24 p.m. It included the following: A grievance form written statement by Resident D on 11/21/23 indicated the resident had concerns with being served at meals by CNA 17. CNA 17 will not serve her meals or coffee. Resident W had stated that the "mistreatment she had towards me was because they were dating also." A written statement by CNA 17 dated 11/21/23 indicated "In the mornings when I come in at 7:30 I jump right in and help with breakfast. they don't have any staff to help out, so we go in and serve everyone. No one gets left out everyone gets serve. No one gets ignored everyone eats. When all the residents are served I will sit down and eat. When I see residents come in they also get served to. Resident W speaks to everyone. he does his own everything only time I see him when he comes in the nurse station to get blood sugar taken. When he buys chicken he gets all the staff chicken. He just like any other resident he speaks and goes about his day." A questionnaire for Resident W stated the following: "1. Has a CNA or nurse ever ignored you or neglected you in the dining room?" The resident answered no, "2. Have you ever observed a CNA or nurse ignore or neglect another resident in the dining			

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	02/29/2024

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
	room?" The resident answered no. The investigation file did not include statements by witnesses, staff members nor Resident W that included dating CNA 17. During a Confidential Interview 20, They indicated CNA 17 was in the dining room cussing and harassing Resident D after an incident was reported to the Administrator by Resident D about CNA 17 on 11/21/23. During a Confidential Interview 21, They indicated they observed CNA 17 in the dining room after the reported incident by Resident D. CNA 17 was observed making comments about the incident in the dining room while Resident D was present. "The B**** thought she got me fired. She told [the Administrator] I was messing around with Resident W." Resident D then moved to outside smoking area, and CNA 17 followed the resident outside arguing with her. They indicated the incident was reported anonymously to either the corporate office or the Administrator. CNA 17 was terminated a few days later. They indicated they were unsure if Resident W was dating CNA 17. An interview was conducted with the Administrator on 2/29/24 at 12:06 p.m. He indicated he did not tell CNA 17, Resident D had reported an allegation about her. During the investigation, it was never confirmed CNA 17 was dating Resident W. CNA 17 was asked to come in and do in-service customer service education after the investigation. She never showed up for work, so she was terminated. The Administer provided a text message chain between Resident D and himself on 2/29/24 at 1:24 p.m. The text messages indicated the following:			

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	02/29/2024

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
	The cell phone text dated 11/23/23 at 9:19 a.m. from Resident D stated, "[The Administrator's name] I know this is your time off, but I wanted to let you know I didn't report [CNA 17] to you all sooner because I knew what was happening to me in the dining room this morning is exactly what I was afraid of, now I don't feel safe here anymore...I really wish I hadn't said anything at all what I was afraid of, now I don't feel safe here anymore....I really wish I hadn't said anything at all." The response stated by the Administrator dated 11/23/23 at 9:55 a.m., indicated "Why don't you feel safe? The response by Resident D dated 11/23/23 at 10:07 a.m., stated, " I'm okay I talked with [CNA 17] we have an understanding." The Administrator's response on 11/23/24 at 10:08 a.m., indicated "ok, let me know if there are any other concerns." The investigation file did not include follow up with Resident D and/or CNA 17 about what happened in the dining room on 11/23/23. An interview was conducted with the Administrator on 2/29/24 at 1:25 p.m. He indicated on 11/23/23, Resident D had sent him some text messages. He had asked the resident why was she afraid, but the next text he received she responded she was okay now. The Administrator indicated he did not follow up with Resident D about the text messages he received on 11/23/23. The resident indicated she was okay. There was no other incidents reported to him involving CNA 17 and Resident D other than what had already been reported about Resident D being ignored in the dining room. CNA 17 was terminated for not showing up for the next scheduled work day and not completing the customer service education. 3. The Abuse policy was provided by the Director			

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	02/29/2024

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
	of Nursing on 2/27/24 at 3:20 p.m. The policy did not include reporting allegations of abuse to the Indiana Department of Health. The abuse policy dated revised date 2/2021 indicated "...Residents of the community have the right to be free of abuse, neglect and financial exploitation. Staff members will conduct themselves in a manner that is respectful and courteous at all times. Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the community...Reporting It is the mandatory for staff members to report suspected incidents of abuse, neglect, and financial exploitation. Staff members are required to immediately report suspect behaviors to their Department Manager. Documentation will be initiated by the Department Manager at the time of the initial report. The Department Manager will immediately inform the Administrator. Once an allegation of abuse has been reported, the accused individual will be immediately removed from the community and suspended pending the outcome of the investigation. Investigation. The Department Manager along with the Administrator will investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the Department Manager and the Administrator. Documentation of the investigation will be maintained by the Administrator. The community will suspend staff involved in the incident pending provider investigation. It is required that the Administrator report the reported incident to the applicable APS [Adult Protective Services] or CPS [Child Protective Services] office. Additionally, DDARS [Division of Disability, Aging, and Rehabilitation Services], shall be notified of the incident on the prescribed incident			

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	02/29/2024

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
	reporting format approved by DDARS within the specified time frame. The community will submit a final report to DDARS that includes how the investigation was handled, final outcome, who was involved, and what steps are being taken to prevent this situation in the future..." The Abuse, Neglect, and Financial Exploitation Prevention policy was provided by the DON on 2/27/24 at 3:20 p.m. It read, "The Department Manager along with the administrator will investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the Department Manager and the Administrator. Documentation of the investigation will be maintained by the Administrator." This Residential Tag relates to Complaint IN00426449.			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (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			

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	02/29/2024

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
	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 conduct fire drills quarterly on each shift for 108 of 108 residents in the facility. Findings include: The fire drills for the calendar year of 2023 were provided by the Administrator on 2/27/24 at 11:30 a.m. They included the following fire drill dates and times: 1/10/23 at 3:15 p.m., 2/21/23 at 8:00 a.m., 3/14/23 at 1:31 p.m., 4/27/23 at 3:00 p.m., 5/25/23 at 3:15 p.m., 6/21/23 at 3:00 p.m., 7/21/23 at 3:00 p.m., 8/23/23 at 7:00 a.m., 9/30/23 at 3:00, p.m., 11/14/23 at 11:00 a.m., and 12/11/23 at 8:30 a.m. The drills included only one third shift drill the entire year and no 2nd shift drill in the final quarter of 2023. An interview was conducted with the Maintenance Director on 2/29/24 at 1:24 p.m. He indicated there were 3 nursing department shifts and he may have only gotten in one 3rd shift drill in 2023. He liked doing drills at 3:00 p.m., because it captured both first and second shifts.	R 0092	R92-Administration and Management Non Compliance- (Fire Drills) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were adversely affected by the deficient practice How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; N/A All Fire Drills Up to date by 5-1-24. Fire Drill Schedule – In Tels April 2024- May 2024 June 2024 July 2024 August 2024 September 2024 September 2024	05/01/2024

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	02/29/2024

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
			October 2024 November 2024 December 2024 **QA Maintenance Manager or designee monthly to assure Fire Drill procedures are completed x 10 months.**	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records.			

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	02/29/2024

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
	(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on observation, interview, and record review, the facility failed to ensure a staff member was given an orientation to the facility prior to working independently and maintain documentation of the orientation in their personnel record for 1 of 1 staff member randomly observed. (Dietary Aide 5) Findings include: The Employee Records form was provided by the Administrator on 2/28/24 at 11:43 a.m. The form indicated Dietary Aide 5 began working at the facility on 2/7/24. On 2/28/24 at 11:45 a.m. through 12:20 p.m., the lunch service was continuously observed in the facility kitchen and dining room. The lunch service had already begun, and many residents had been served. As the residents finished their meals and left the dining room, other residents began coming into the dining room sporadically, sitting at the tables that had soiled dishes and silverware on them. The kitchen staff were taking the orders of the residents who had just arrived and delivering food to them. The silverware storage container was observed to not have silverware. A dish machine rack was observed on the clean side of the dish machine with 2 forks and a knife in the rack. Facility Cook 15 indicated that the kitchen ran out of silverware sometimes. The residents who had just received their meals started to ask for silverware. Dietary Aide 5 was	R 0119	R119- Personnel- Non Compliance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice : No residents were adversely affected by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: N/A All staff files to be reviewed for accuracy. All new hires will complete orientation list prior to starting active employment **QA- Weekly BOM or designee – After review of current employees initiate weekly review of new hires weekly x 12 weeks, Monthly x 3 months then PRN thereafter if continued compliance is attained.**	05/01/2024

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	02/29/2024

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
	observed bringing out boxes of plastic silverware to use but returned the plastic silverware to the kitchen without passing it out. The silverware storage container continued to be without silverware and the clean dish rack continued to have 2 forks and 1 knife. At 12:20 p.m., Dietary aide 5 was observed with a handful of silverware and handed silverware to Resident 103, who started to eat his meal. Dietary Aide 5 indicated he had gotten the silverware from the kitchen and had washed it. Dietary Aide 5 demonstrated that he had put household dish soap on the silverware and used the hand sprayer to spray it off. The silverware had not gone through the dish machine to be washed and sanitized. An interview was conducted with the BOM (Business Office Manager) on 2/28/24 at 4:18 p.m. She indicated she was unable to provide documentation of Dietary Aide 5's orientation to the facility, because he just started working at the facility on 2/7/24, and they had a month to complete orientation. She was unsure if their facility policy allowed for a month to complete orientation, but that was their typical practice. A blank copy of the Orientation & Training checklist for a Dietary Aide was provided by the Administrator on 2/29/24 at 1:23 p.m. It included Equipment Use and Serving Procedures. There were fields for the supervisor to date and initial for each area as well as the employee's signature. The Personnel Records policy was provided by the Administrator on 2/29/24 at 1:23 p.m. It read, "PROCEDURE: A. Upon employment, a personnel file will be established. The Administrator or his/her designee will assure that all documents are signed prior to but no later than the completion of the person's first day of			

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	02/29/2024

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
	employment....E. The following documents will be retained in the personnel file or separate file as appropriate: ...3. Orientation checklist.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants.			

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	02/29/2024

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
	(E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure a staff member had dementia training within 6 months of hire for 1 of 5 staff members reviewed for dementia training. (Dietary Aide 4) Findings include: The Employee Records form was provided by the Administrator on 2/28/24 at 11:43 a.m. The form indicated Dietary Aide 4 began working at the facility on 8/1/23. An interview was conducted with the BOM (Business Office Manager) on 2/29/24 at 11:27 a.m. She indicated she was unable to provide verification of Dietary Aide 4's dementia training, because Dietary Aide 4 hadn't completed any of her trainings by a specific provider of education, training, and workforce enablement solutions for human services and healthcare organizations.	R 0120	R120 Personnel Noncompliance-Dementia Training What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were adversely affected by this deficient practice How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: N/A All staff to be evaluated for completion of 6 hour dementia training within 6 months upon hire and 3 hours annually thereafter BOM or ED New hires to complete Relias training for Dementia 6 hours training within 6 months and 3 hours annually thereafter **QA- Monitor Dementia specific training within 6 months upon hire and 3 hours annually thereafter monthly x 12 months**	05/01/2024
R 0153 Bldg. 00	410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen.	R 0153	R153	05/01/2024

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	02/29/2024

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
	Based on observation, interview, and record review, the facility failed to properly store oxygen and assure the safe handling of oxygen. This failure resulted in a resident being burned while attempting to light a cigarette while wearing oxygen for 1 of 1 resident reviewed for oxygen storage (Resident C). Findings include: The clinical record for resident C was reviewed on 2/27/24 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, chronic obstructive pulmonary disease (restricted breathing) and hypertension. A Late Entry Progress Note, dated 2/3/24 at 11:45 p.m., indicated Resident C was sent to the hospital for burns to his face. Resident B had come down to the office and stated he had burned his face. Resident B had light a cigarette while wearing his oxygen. Burns were visible all over his face. The Director of Nursing and Resident B's family member were notified of the transfer. On 2/27/24 at 3:04 p.m., the ED (Executive Director) provided the incident report which had been submitted to the Indiana Department of Health on 2/4/24 which indicated Resident B had suffered burns to his face and mouth from apparently smoking while using oxygen in his apartment. The type of injury was listed as superficial burns to the face and mouth. The immediate actions taken were that he was rushed to the hospital via emergency medical services for evaluation and treatment. The preventative measures taken were to educate him when he returned from treatment about the dangers of smoking while using oxygen and the facility		**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 that smoke that require the use of oxygen had the potential to be affected by the alleged deficient practice. DON, ADON, Executive Director or designee will monitor rooms and designated smoking areas of all residents on oxygen, whom smoke. Each shift and periodically, the current rooms and designated areas will be checked for evidence of smoking with oxygen. Any resident found to be out of compliance, will be asked to leave cigarettes and lighters with staff. They will then be able to check them out when needed and when smoking in designated areas only. Residents found to be out of compliance will be issued a violation of lease warning and discharged from community. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	

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	02/29/2024

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
	would seek alternate placement for Resident B as he had violated his lease. During an interview on 2/27/24 at 2:32 p.m., QMA (Qualified Medication Aide) 8 indicated that Resident B had been burned while trying to smoke with his oxygen on. Resident B had frequently smoked in his apartment prior to the incident on 2/3/24. He had never been caught with a lit cigarette, but the smoke could be smelled in his apartment. He had stopped since he was burned. During an interview on 2/27/24 at 2:34 p.m., LPN (Licensed Practical Nurse) 11 indicated Resident B had smoked in his apartment prior to the incident on 2/3/24. On 2/28/24 at 11:15 a.m., Resident B was observed in his apartment. A sign was hanging outside of his door which read "DANGER OXYGEN IN USE NO SMOKING OR OPEN FLAME". Resident C's face had multiple round scarred areas around his nose and forehead. His thumb and first finger on his right hand had scarred areas on them. Resident B indicated that he had burned himself while lighting a cigarette with his oxygen on and the scars on his face and hand were from where he was burned. The wounds had "healed up pretty well". A glass ashtray was observed sitting by his easy chair with cigarette buts present in the ashtray. Oxygen cylinders were observed in his room approximately 6 feet from his easy chair. An oxygen concentrator was running, and green oxygen tubing was noted to be coming from the oxygen concentrator and was draped on the arm of his easy chair. On 2/28/24 at 11:35 a.m., the DON (Director of Nursing) and the BOM (Business Office Manager) were interviewed. The DON indicated he was not		**practice does not recur:** a DON, ADON, Executive Director or designee will monitor rooms and designated smoking areas of all residents on oxygen, whom smoke. Each shift and periodically, the current rooms and designated areas will be checked for evidence of smoking with oxygen. Any clinical staff member out of compliance with facility's policies and protocols relating to smoking with oxygen, will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to smoking with oxygen 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 DON, ADON, Executive Director or designee will monitor rooms and designated smoking areas of all residents on oxygen, whom smoke. Each shift and periodically, the current rooms and designated areas will be checked for evidence of smoking with oxygen. Results to be reviewed at monthly QI meetings and make further recommendations based off	

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	02/29/2024

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
	aware that Resident C had smoked in his apartment prior to the 2/3/24 incident and was unsure why there was an ashtray with cigarette buts present in his room. The BOM indicated that she was unaware that Resident C had smoked in his apartment prior to the incident, however had seen the ashtray with cigarette butts in it the day Resident C had gotten back from the hospital. The BOM felt the ashtray had not been emptied since Resident C had returned from the hospital on 2/4/24. The DON indicated that Resident C received nursing care in his room prior to the 2/3/24 incident and the staff should have made the DON aware that Resident C was smoking in his room, as it was a safety hazard. On 2/28/24 at 12:06 p.m., the ED provided the Oxygen Use and Storage Policy and Procedure, Approved 3/2022, which read "...It is the policy of this community to ensure resident has access to oxygen as ordered by the physician through vendor of choice, to ensure safe handling of compressed gasses, oxygen delivery systems and equipment and to assist resident with handling, storage and management of oxygen equipment...The community staff will routinely observe rooms of oxygen users to ensure that oxygen cylinders are properly secured..."		audit results **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 5-1-24.	
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure the dumpster area was clean with trash contained in dumpsters	R 0155	R155-Safety and Sanitation Standards-Deficiency What corrective action(s) will be	05/01/2024

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	02/29/2024

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
	for 1 of 1 dumpster area observed. Findings include: An observation was made of the fenced in dumpster area on 2/27/24 at 11:22 a.m. The two gates of the dumpster area were observed open and missing wood planks. 1 dumpster lid was open. The ground surrounding the dumpsters was observed with trash bags split opened with scattered food, paper products, gloves, masks, plastic and glass bottles, over-the-counter medications, 2 mattresses, 1 box spring and 1 broken bottle half of a recliner. The outside of the dumpster area was observed with trash debris on the ground. A few feet away from the dumpster area plastic bags and paper product trash debris were observed stuck in the trees and under the wood brush that was next to a school with a playground. A recycle dumpster was observed in the parking lot. The dumpster was full of cardboard boxes and the two lids open. An observation was made of the dumpster area with the Maintenance Manager (MM) on 2/27/24 at 11:36 a.m. The inside and outside dumpster area was observed. The MM indicated the furniture was from previous residents that move out of the facility. The trash debris in the trees and wood brush could be some of the facility trash, but it could also be others in the community. The lid on the dumpster was observed to be warped, and the maintenance man had to push hard to be closed. The waste management company empties the dumpsters 5 times a week, The waste company staff are suppose to get out and pick up trash bags that fall out when emptying but they don't. It has been approximately a month since the dumpster area has been picked up. The missing wood planks on the gate has been missing a		accomplished for those residents found to have been affected by the deficient practice : No residents were adversely affected by this deficient practice How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; N/A New Dumpster to be requested (Warped Lid) Staff education documented regarding refuse removal from building **QA-Maintenance Manager or designee-Bi weekly inspection of Dumpster Area x 8 weeks, then weekly x 4 then PRN thereafter if continued compliance is attained.**	

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	02/29/2024

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
	couple of years. The condition of the dumpster area "it comes and goes" on the degree of trash debris lying on in the dumpster area. He uses a shovel to clean up the area. The recycle dumpster was observed full with cardboard boxes both top lids open. The MM indicated the lids should be closed. A "Waste Removal Policy and Procedure" policy was provided by the Administrator on 2/29/24 at 8:40 a.m. It indicated "...Collected rubbish shall be placed in the facility's outdoor dumpster. The dumpster shall be emptied by an approved refuse hauler at a minimum of once per week, or more often as necessary to prevent overloading of the dumpster and to minimize odors and pests. The dumpster must also be equipped with a lid than can be easily opened and closes completely..."			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure a resident was provided with their medication and check their blood pressure, as ordered, arrange transportation for a resident to attend scheduled appointments, and failed to assure medications were administered per the service plan for 2 of 5 residents whose records were reviewed. (Resident E and Resident C) Findings include: 1. a) The clinical record for Resident E was reviewed on 2/28/24 at 11:00 a.m. Her diagnoses included, but were not limited to, hypertension, anxiety, and depression.	R 0240	R240 **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a Resident C and E experienced no adverse effects from the alleged deficient practice. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and**	05/01/2024

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	02/29/2024

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
	The 10/31/23 annual service plan indicated nursing staff would provide Resident E with assistance with her medication at the task level of "administer." It indicated she needed/had requested help with transportation with an objective to attend medical appointments and maintain wellness as possible. The 11/30/23 Physician 25 note indicated the following 4 appointments and referrals were made today: 12/7/23, 1:30 p.m. MRI (magnetic resonance imaging) lumbar spine without contrast; 12/21/23, 10:45 a.m. nurse practitioner follow up; 1/11/24, 10:15 a.m. physician appointment with Physician 25; and 2/1/24, 2:30 p.m. neurology consult. The goals indicated on the note were to check her blood pressure daily; to follow her medication regimen; and to maintain her medical appointments. The physician's orders for Resident E indicated to administer one 25 mg tablet of Topiramate daily at bedtime, effective 12/1/23; one 100 mg tablet of Trazodone daily at bedtime, effective 12/24/23; and to check her blood pressure on Mondays, Wednesdays, and Fridays, effective 2/1/23. The February, 2024 MAR (medication administration record) indicated the Topiramate was not administered on the following dates: 2/7/24, 2/11/24, 2/14/24, 2/16/24, 2/19/24, and 2/26/24. The Trazodone was not administered on the following dates: 2/7/24, 2/11/24, 2/14/24, 2/16/24, 2/19/24, and 2/16/24. Her blood pressure was not taken on the following dates: 2/2/24, 2/5/24, 2/7/24, 2/12/24,, 2/14/24, 2/16/24, 2/19/24, 2/21/24, 2/23/24, and 2/26/24. The only date her blood pressure was taken in February, 2024 was on 2/9/24.		**what corrective action will be taken;** a All residents requiring assistance with medication administration, by the facility, had the potential to be affected by the alleged deficient practice. DON and/or designee will in-service clinical staff on procedures of medication administration and properly following doctor's orders. DON and/or designee will audit eMAR for any unattended medications and/or orders and have the staff address within 24 hours. Employees found to be out of compliance with medication documentation will receive additional education and 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;** a All clinical staff will be re-educated and in-serviced on medication administration and properly following doctor's orders no later than 5-1-24. Any clinical staff member out of compliance with facility's policies and protocols relating to medication administration and properly following doctor's orders, will receive progressive corrective action, including termination. The	

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	02/29/2024

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
	An interview was conducted with Resident E on 2/28/24 at 3:39 p.m. She indicated sometimes she received her medications, and sometimes nursing staff "just don't give it to me." When they didn't give it to her, she didn't do anything about it, she just didn't take it. She was on a medication for a nervous condition and was supposed to receive it at night, but didn't always get it and had issues sleeping this month. The facility was not checking her blood pressure 3 times a week, and had only done it once "when I fell out." Physician 25 was her doctor and she needed to see her, but she didn't have any way of getting there. Resident E provided a copy of the 11/30/23 Physician 25 note with the scheduled appointments and referrals and indicated she'd given the facility a copy of it. An interview was conducted with Resident E on 2/29/24 at 11:20 a.m. She indicated she didn't go to any of the 4 scheduled appointments, because the facility wouldn't help her set up transportation. An interview was conducted with the DON (Director of Nursing) on 2/29/24 at 11:00 a.m. He reviewed Resident E's clinical record and indicated he didn't see any verification she went to any of the 4 scheduled appointments. It was in her service plan to help assist her with transportation, so they were supposed to assist her. The missed administrations of Trazodone and Topiramate were not documented as being administered, so he couldn't verify she received them. 2. The clinical record for resident C was reviewed on 2/27/24 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, chronic obstructive pulmonary disease (restricted breathing) and hypertension. A Self Medication Assessment, dated 1/25/24, indicated that Resident C required medication to		Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols relating to medication administration and 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 the eMAR five (5) times per week for eight (8) weeks, then three (3) times a week for four (4) weeks, then two (2) times a week for four (4) weeks and then weekly for eight (8) weeks, then as needed to ensure that proper medication administration and documentation is being executed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5 By what date the systemic changes will be completed;** a 5-1-24	

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	02/29/2024

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

be stored and locked due to poor safety awareness.

A Resident Service Plan, last updated 2/6/24, indicated Resident C needed assistance with ordering and setting up medications. The goal was for him to follow medication regimen as ordered by his physician. The services to be provided included, but were not limited to, nursing staff will provide Resident C with assistance at the following level: administer.

On 2/28/24 at 11:15 a.m., Resident C was observed in his apartment. A plastic medication cup with pills inside of it was observed sitting on his kitchen counter and another plastic medication cup with pills was observed on his coffee table. Resident C indicated that the plastic medication cup of pills on the coffee table were his morning medications. The nurse had dropped them off for him to take.

During an interview on 2/28/24 at 11:35 p.m., the DON (Director of Nursing) indicated that Resident's medications should not have been left in his apartment. The nursing staff should have watched Resident C take his medications.

On 2/28/24 at 11:32 a.m., the Assistant Director of Nursing provided the Medication Management Administration, and Storage Policy which read "...If a resident is assessed as Needing Assistance with Medication Administration, it is the responsibility of the licensed nurse or Qualified Medication Aide [QMA] to administer the medications to the resident..."

This Residential Tag relates to Complaint IN00426449.

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	02/29/2024

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 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation, interview, and record review, the facility failed to ensure the individual administering medications to a resident documented the administration in the medication record timely for 5 of 5 medication administrations observed. (Residents 2, 12, 38, and 43) Findings include: A medication administration observation was conducted with QMA (Qualified Medication Assistant) 7 on 2/28/24 starting at 11:09 a.m. Upon entrance into the nursing station, QMA 7 had all the "noon" meds pulled for her residents. She had placed the pill pouches, med cups, and water cups into a large plastic bag which was sitting on the counter in the nursing station. 1. QMA 7 picked up the large plastic bag and headed to Resident 12's room first. QMA 7 did not have a computer, a paper MAR (medication administration record) or a computer with her as she left the nursing station. QMA 7 entered Resident 12's room, retrieved a medication cup, the pill packet, and water cup from the large plastic bag. She dispensed the medications into the cup and handed them to Resident 12. After Resident 12 was done, QMA 7 left the room and went to find the next resident. QMA 7 did not	R 0243	R243 **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 medications, 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 medication administration 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**	05/01/2024

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	02/29/2024

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
	immediately document the administration of the medications. 2. QMA 7 found the next resident, Resident 43, in the hallway near the elevator by the dining room. QMA 7 prepped the medication and water then administered the medication to Resident 43. Once completed, QMA 7 left to find the next resident. QMA 7 did not immediately document the administration of the medications. 3. The next resident to receive medications was Resident 25. QMA 7 found him sitting outside in the smoking area. QMA 7 prepped Resident 25's medications inside then proceeded outside to administer them. QMA 7 administered the medications to the resident and left to find the next resident. QMA 7 did not immediately document the administration of the medications for Resident 25. 4. Resident 38 was located in the therapy room. QMA 7 prepped and administered Resident 38's medications and left. At the time of administration of medications to Resident 38, QMA 7 did not immediately document the administration of the medications. 5. Resident 2 was located in the hallway near the elevator and nursing station. QMA 7 prepped and administered the medications to Resident 2. After administering the medication to Resident 2, QMA 7 stated she was done with med pass. During the medication administration observation, the documentation of the administrations in each resident's clinical record had not been observed. An interview with QMA 12 conducted on 2/28/24 at 11 a.m. indicated, when documenting		**into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** 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	

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	02/29/2024

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
	medication administrations, they are supposed to use the tablets the facility provides to take with them when doing med pass to document as they go. She also stated, during COVID times they were allowed to come back to the nursing station and use the computer to chart the medication administration but, now that things are "getting back to normal" they are supposed to use the tablets. An interview with DON (Director of Nursing) conducted on 2/28/24 at 4:20 p.m. indicated, medications administered are to be documented immediately following the administration to the resident. He stated, the facility has tablets which are to be used for medication administration documenting at time of administration. DON indicated, the charging cords for tablets once were super glued to the counter in nursing stations for the tablets and yet those disappeared so then the tablets don't get charged and when they (nursing staff) go to use them, the tablets are dead. A Medication Management, Administration , & Storage policy received on 2/28/24 at 10:18 a.m. from DON indicated, "Medication Administration: Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or QMA...The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation....Documentation: At the time of administration, the licensed nurse of QMA administering the medication will document the administration in the medication (or treatment) administration record that includes the following: a. Resident Name		**5 By what date will the systematic changes be completed** a Education and in-service will be provided to all clinical staff on 5-1-24.	

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	02/29/2024

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
	b. Name of medication or Treatment c. Date, Time d. Route e. Dosage (if applicable) f. Name or initials of the person administering the drug or treatment g. Response to medication for all PRNs [sic, as needed] and if indicated."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure the kitchen was clean; in good repair; had accessibility of hand soap and paper towels; food stored was labeled, dated and closed; dietary staff covered facial hair; the availability of the main choice meals for all the residents ; and to ensure silverware was washed in the dish machine prior to use for 1 resident randomly observed and with the potential to affect 108 of 108 residents that reside in the facility. (Resident 103). Findings include: 1 a. A kitchen tour was conducted on 2/27/24 at 11:04 a.m., with Cook 15 and Cook 16. The hand hygiene station was observed with Cook 15. He reported the wall soap dispenser was broken. A bag of soap that had been in the dispenser was sitting on the edge of the sink. He demonstrated how to manipulate the soap bag by pumping and twisting a knob on the soap bag for soap to come out of the bag. The walls in the dishwasher area was observed to have yellow stained substance	R 0273	R273- Food and Nutritional Services Deficiency- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice : No residents were adversely affected by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be adversely affected by the deficient practice All dietary staff education on cleaning list assignments and completion/ sign off sheet, pre-bussing tables, Overall kitchen cleanliness per Dietary Manager Resident education on Always Available list, second	05/01/2024

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	02/29/2024

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
	and the drains contained food debris. The ceiling tiles and vents above food prep areas had black substance. Cook 15 indicated the vents were suppose to be replaced soon. The steam table had black substance dripped on it. The dry food storage area was observed with Cook 16 that had 1 bin with oats, 1 bin with floor and 1 bin with sugar. All 3 bins had lids not closed with 1 bin had a scoop sitting on top of the open lid. 1 bin sitting on a shelf contained corn starch had 2 ketchup packets lying inside the corn starch, and the lid was sideways lying inside in the corn starch; yellow cake mix bag sitting on a shelf was opened to air and no date; a white container of chicken base was sitting on a shelf was open to air with lid not closed all the way nor dated. Cook 16 indicated the dietary on night shift was new and did not know how to close the bins. A refrigerator in the kitchen prep area was observed with Cook 16. It contained containers of tomatoes, diced ham, chicken not labeled or dated. A container of shredded cheese was opened to air with no lid covering with no label or date. Cook 16 indicated all food should be covered and dated. Then the walk-in refrigerator was observed with Cook 16. A bag of sausage was observed opened to air, not labeled or dated; pitchers of orange juice and apple juice; a package of shredded cheese all observed not labeled or dated. The walk-in freezer was observed with water drippings that had turned into large ice drippings from the top rack to the bottom rack covering boxes of cinnamon rolls, bread sticks, chicken and pie crusts. A pork loin was on its side frozen to one of the cardboard boxes sitting on the bottom rack. At that time, Cook 16 pulled the pork loin from the card board box and placed it on a silver tray next to the cardboard box it was attached to. A bag of potato cakes was observed open to air with no label or date. Cook 16 indicated at that time the		helpings and to go orders **QA- Dietary Manager or Designee- Food Dated/ Labeled and closed daily x 60 days- 3 x weekly x 30 days- wkly x 30 days then PRN thereafter if continued compliance is attained** **QA Dietary Manager or Designee- Bins closed BID x 60 days- 3x weekly x 30 days-Weekly x 30 days then PRN thereafter if continued compliance is attained** **QA- Dietary Manager or Designee -Hair and facial coverings TID with meals x 60 days-3x weekly x 30 days-Weekly x 30 days then PRN thereafter if continued compliance is attained** **QA- Dietary Manager or Designee- Main course availability 2 meals daily x 60 days- 3x weekly x 30 days- weekly x 30 days then PRN thereafter if continued compliance is attained** **QA- Dietary Manager or Designee- Hand Sanitizer and soap availability daily x 4 weeks, 3 x weekly x 4 weeks then PRN thereafter if continued compliance is attained**	

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	02/29/2024

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
	frozen water drippings was because 1 fan in the freezer was broken and did not work. The fans were observed with 1 fan working and 1 fan not. She had noticed the broken fan over the weekend, but had not reported to the maintenance department the freezer fan was broken. After, A weekly cleaning schedule dated 2/25/24 through 3/2/24 was observed taped to the Dietary Manager's office door. The cleaning schedule tasks was blank and not signed off by dietary staff the completion of cleaning tasks. Cook 16 indicated the cleaning tasks had been completed, but the staff had not signed off on the sheet. A kitchen tour was conducted on 2/28/24 at 11:28 a.m., with Cook 15 and Cook 16. The hand hygiene station was observed with the soap dispenser broken. A bag of soap was sitting on the sink. Cook 15 had manipulated by pumping and twisting a top on the soap bag to expel the soap. The walls in the dishwasher area were observed to be stained with yellow substance. The drain under the dishwasher was observed to have food debris. The steam table was observed to have black substance drippings. The dry storage area was observed with a white cup that contained sugar on a shelf opened to air not labeled or dated. An interview was conducted with Cook 15 and Cook 16 on 2/28/24 at 11:35 a.m. After food temperatures of the lunch meal, Cook 15 and Cook 16 indicated the residents have meal choices. They offer the main meal choice, and the resident also has additional meal choices if the resident does not like what was being served as the main choice. The resident may also choose to have a hamburger, a salad, a grilled cheese or a fried egg sandwich. The staff are able to eat the main meal prepared, but they have to wait until 1:00 p.m., which was after all the residents have eaten. Not		Dietary Manager to ensure all areas are in compliance daily.	

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	02/29/2024

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
	all the residents eat out of the kitchen for all meals prepared. There are times, the kitchen will prepare a meal that a lot of the residents enjoy, and they do run out of the main meal choice if it was a favorite. "For example: fried chicken." If they do run out, the resident will then need to choose from their alternative choices which was a hamburger, a salad, a grilled cheese or a fried egg sandwich. A lunch meal service was observed in the dining room on 2/28/24 at 11:43 a.m. The hand hygiene station in the beverage area was observed with no accessible hand soap in the soap dispenser or paper towels. During the meal service, a female resident indicated the kitchen does at times run out of the main meal choice. She has had to receive a hamburger, because the main meal choice was no longer available. A male resident indicated the kitchen runs out of food all the time. During a Confidential Interview 5, they indicated the kitchen runs out of the main meal served often. During A Confidential Interview 6, they indicated the kitchen utensils and cups are always dirty. During a Confidential Interview 11, they indicated the kitchen runs out of the food often. A Kitchen tour was conducted with the Administrator on 2/29/24 at 8:46 a.m. The hand hygiene station in the beverage area was observed to not have soap available in the soap dispenser nor paper towels. The hand hygiene station in the kitchen was observed to have a bag of soap sitting on the edge of the sink. The soap bag had to be manipulated by the Administrator			

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	02/29/2024

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
	pumping and twisting to expel the soap. During the tour, the walls in the dishwasher area were observed to be stained yellow, and the drain under the dishwasher had food debris. The ceiling tiles and vents were observed with black substance, and the steam table had black substance drippings. The dry storage area had 1 white cup with sugar in it opened to air with no label or date. The walk-in freezer was observed with 1 fan broken and frozen water ice cycles from the top shelf to the bottom. The frozen ice was on top of pie crusts and boxes of cinnamon rolls, chicken and bread sticks. A bag of chicken was open to air. The weekly cleaning schedule dated 2/25/24 through 3/2/24 was hanging on the Dietary Manager's office door not signed off the daily cleaning tasks had been completed. Dietary Staff 5 was observed at the food prep area with facial hair on his top lip, sides of his mouth and his chin (goatee) with no beard cover. After, the Administrator and Cook 16 had entered the Dietary Manager's office looking for beard coverings. Cook 16 indicated they did not have any beard coverings for the staff with facial hair. The January 2024 and February 2024 weekly daily cleaning schedules were provided by the Administrator on 2/29/24 at 9:36 a.m. It indicated the following: 1/1/24 - 1/6/24 daily cleaning schedule - the steam table was not signed off as being cleaned after each meal on 1/4/24, 1/5/24 and 1/6/24, 1/7/24 - 1/13/24 daily cleaning schedule - the steam table was not signed off as being cleaned after each meal on 1/7//24, 1/12/24 and 1/13/24, 1/14/24 - 1/20/24 daily cleaning schedule - the steam table was not signed off as being cleaned			

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	02/29/2024

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
	after each meal on 1/14/24, 1/15/24, 1/16/24, 1/17/24, 1/18/24 and 1/19/24, 1/21/24 - 1/27/24 daily cleaning schedule - the steam table was not signed off as being cleaned after each meal on 1/21/24, 1/22/24, 1/25/27, 1/26/27, and 1/27/24, 1/28/24 - 2/3/24 - no daily cleaning schedule provided, 2/4/24 -2/10/24 - no daily cleaning schedule provided, 2/11/24 - 2/17/24 - no daily cleaning schedule provided, 2/18/24 - 2/24/24 - no daily cleaning schedule provided An interview was conducted with the Administrator on 2/29/24 at 3:30 p.m. He indicated the Dietary Manager does order enough food for all the residents. Even though, not all the residents eat food served out of the kitchen for all the meals. The Dietary Managers keeps tracks and has numbers how many residents eat the meals. The breakfast meal has the least amount of residents that attend. The lunch meal had a little more resident attendance, and the dinner had the most resident attendance that eat food prepared in the kitchen. 1 b. During an interview on 2/27/24 at 3:28 p.m., Resident M indicated that the kitchen staff were taking dirty dishes and silverware off of the tables and rinsing them off in the sink then reusing them for other residents. The staff did this "all the time" and the used dishes and silverware were not going through the dishwasher in the kitchen. The staff were not properly trained. He had seen it			

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	02/29/2024

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
	happen. On 2/28/24 at 11:45 a.m. through 12:20 p.m., the lunch service was continuously observed in the facility kitchen and dining room. The lunch service had already begun, and many residents had been served. As the residents finished their meals and left the dining room, other residents began coming into the dining room sporadically, sitting at the tables that had soiled dishes and silverware on them. The kitchen staff were taking the orders of the residents who had just arrived and delivering food to them. The silverware storage container was observed to not have silverware. A dish machine rack was observed on the clean side of the dish machine with 2 forks and a knife in the rack. Facility Cook 15 indicated that the kitchen ran out of silverware sometimes. The residents who had just received their meals started to ask for silverware. Dietary Aide 5 was observed bringing out boxes of plastic silverware to use but returned the plastic silverware to the kitchen without passing it out. The silverware storage container continued to be without silverware and the clean dish rack continued to have 2 forks and 1 knife. At 12:20 p.m., Dietary aide 5 was observed with a handful of silverware and handed silverware to Resident 103, who started to eat his meal. Dietary aide 5 indicated he had gotten the silverware from the kitchen and had washed it. Dietary Aide 5 demonstrated that he had put household dish soap on the silverware and used the hand sprayer to spray it off, the silverware had not gone through the dish machine to be washed and sanitized. During an interview on 2/28/24 at 2:45 p.m., the Executive Director indicated that soiled dishes and silverware should be ran through the dish machine prior to using them.			

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	02/29/2024

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
	On 2/29/24 at 8:40 a.m., the Executive Director provided the Dishes, Tableware, Utensils, and Equipment Storage Policy and Procedure, approved 12/2023, which read "...Cleaned and sanitized equipment and utensils should be handled in a way that protects them from dust, dirt, food particles and any other contamination..."			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation and interview, the facility failed to ensure prescription drugs labels were affixed to medications and included: the resident's full name; physicians name; a prescription number; directions for use; date of issue; and name and address of the pharmacy that filled the prescription for 1 of 1 medication rooms reviewed at the facility. Findings include: An observation of the facility's only medication room was conducted on 2/28/24 at 8:47 a.m. with	R 0301	R301 **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;**	05/01/2024

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	02/29/2024

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
	QMA (Qualified Medication Assistant) 7. In the medication room on the main level by the nursing station, the following was observed in the medication refrigerator: 1. A clear plastic bin contained 29 Trulicity (a diabetic and weight loss medication) pens. The plastic bin had a handwritten blue piece of paper taped to the top which had Resident 111's name and room number on it. The 29 individual pens did not contain: the resident's full name, physician's name, a prescription number, directions for use, date of issue, or the name and address of the pharmacy. 2. An unopened vial of Lantus (a diabetic medication) and an unopened vial of methotrexate (a medication for cancer). Neither of the vials had labels affixed to them with the following information: resident's full name, physician's name, prescription number, directions for use, date of issue, or the name and address of the pharmacy that filled the prescription. An interview with QMA 7 was conducted during the medication room observation. QMA 7 indicated, Resident 111 had brought in medications from home which included the unlabeled 29 Trulicity pens and the many unopened boxes of Humira (an immunosuppressive medication) An interview with DON (Director of Nursing)2/28/24 @ 10:04 am indicated, he was unaware of the unlabeled medications, the clear plastic bin of Trulicity pens. He also indicated, the facility did not have a policy for medications brought from home without the proper labeling but rather provided their pharmacy's service guide.		a All residents had the potential to be affected by the alleged deficient practice. DON or designee will do an audit of the medication room to ensure medications are properly labeled in accordance with the state regulation: (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. **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 An audit of the medication room will be conducted by the DON or designee. Any prescription medications found to not be properly marked with all identifying factors, will be promptly destroyed. The Director of Nursing, or designee will educate	

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	02/29/2024

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
	The pharmacy's service guide, received on 2/28/24 at 10:18 a.m. from DON indicated, "All medications are to be stored, handled according to individual professional licensure, federal, state and local ordinance." A Medication Management, Administration, & Storage policy received on 2/28/24 at 11:32 a.m. from ADON (Assistant Director of Nursing) indicated, "Pharmacy Pill Packaging and Scheduling: If the Community is offering medication administration services for a resident, for quality and safety purposes, the resident will have all medications packaged in pharmacy prepared pill package..."		all newly hired clinical staff on policies and protocols relating to labeling of prescription drugs 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 the medication room two (2) times per week for eight (8) weeks, then one (1) time a week for four (4) weeks, and then as needed to ensure that any prescription medication that are not properly labeled are discarded. 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 be provided to all clinical staff between now and concluding on 5-1-24.	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and			

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	02/29/2024

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
	disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.			
	Based on observation and interview, the facility failed to ensure the timely disposal/disposition of medications for discharged residents, expired medications, and expired medication administration supplies for 1 of 1 medication rooms observed for medication storage. Findings include: A medication storage observation was conducted on 2/28/24 at 8:42 a.m. with QMA (Qualified Medication Assistant) 7. In the medication room on the main level, within the nursing station, the following was observed: 1. Inside of a drawer within the medication room were medication pill packets (several administrations/days) for Resident 116. The pill packets contained: One Tylenol 325 mg (milligrams) tablet (pain reliever) Two antacid 500 mg tablets One Ducolax 60 mg tablet (stool softener) Two Eliquis 5 mg x 2 tablets (anticoagulant) One folic acid 1 mg tablet (supplement)	R 0306	R306 **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 receiving medication 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 proper and timely destruction of expired or discontinued medications. Employees found to be out of compliance with proper disposal of medications will receive additional	05/01/2024

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	02/29/2024

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
	Three tablets of Gabapentin 100 mg (nerve pain medication) One tablet of Jardiance 10 mg (diabetic medication) Two tablets of metoprolol 25 mg (blood pressure medication) One omeprazole 40 mg tablet (reduces stomach acid production) Three phenytoin 100 mg tablets (anticonvulsant) Two Torsemide 20 mg tablets (diuretic) One Trajenta 5 mg tablet (diabetic medication) Two Senna 8.6 mg tablets (stool softener) An interview with QMA 7 conducted at the same time as the observation indicated, Resident 116 was no longer a resident at the facility. The clinical record for Resident 116 indicated, the resident was discharged from the facility on 11/10/23. 2. Inside the medication refrigerator the following was observed: a. 3 unopened vials of Lantus 100u/ml (units per milliliter)(diabetic medication) and an unopened glucagen 1 mg pen (used to treat low blood glucose) for Resident 118. The clinical record for Resident 118 indicated, they were discharged from the facility on 10/12/23. b. One unopened vial of methotrexate 50 mg/2ml (cancer medication) for Resident 117. The clinical record for Resident 117 indicated, they were discharged from the facility on 12/5/23. c. One opened methotrexate vial with an opened date of 12/19/23 and an expiration date of 10/23; and an unopened vial of methotrexate with an expiration date of 10/23 for Resident 111. 3. Inside the medication cabinets within the		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:** a Director of Nursing or designee with provide education to all QMAs and Nurses on the timely and proper disposal of expired and discontinued medications no later than **5-1-24**. Any clinical staff members out of compliance with facility's policies and protocols relating to appropriate disposal of medications will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to medication disposal 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 the medication room and residents' medication cabinets two (2) times per week for eight (8) weeks, then one (1)	

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	02/29/2024

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
	medication room, the following was observed: a. A white box, identified by QMA 7 as the facility's emergency drug kit (EDK). Pasted to the top of the box was a list of medications contained within the box and handwritten in blue ink was "Exp 2/15/24". The following medications inside the EDK box had an expiration date of 2/15/24: - Cephalexin 500 mg x 10 tablets (antibiotic) - Ciprofloxacin 250 mg x 6 tablets (antibiotic) - Nitrofurantoin mono-macro (Marcrobid) x 6 tab (antibiotic) - Amoxicillin 250 mg x 12 tablets (antibiotic) - Cephalexin 250 mg tablets x 12 (antibiotic) - Diphenhydramine 25 mg x 6 tablets (antihistamine) - Lasix 40 mg tab x 6 (diuretic) - Warfarin 2.5 mg x 6 tablets (anticoagulant) - Warfarin 1 mg tablets x 6 - Warfarin 2mg tab x 6 - Warfarin 5 mg tablets x 6 - Prednisone 10 mg tablets x 6 (steroid) - Warfarin 3 mg tablets x 6 - Amoxicillin 500 mg x 2 tablets (antibiotic) - Prednisone 20 mg x 6 tablets (steroid) - Bactrim 800/160 mg tablets x 6 (antibiotic) - Levofloxacin 500 mg x 6 (antibiotic) - Potassium 10 meq(millequivalents) tablets x 6 (supplement) - Augmentin 500-125 mg x 4 tablets (antibiotic) - Augmentin 875-125 mg tablets x 6 b. A box containing syringes contained: eight 1 ml syringes with an expiration date of 12/31/21; and one 3 ml syringe with an expiration date of 8/31/22. The facility's pharmacy Service Guide received on 2/28/24 at 10:18 a.m. from DON (Director of Nursing) indicated, under Destruction/returns "Due to regulatory and licensing requirements the pharmacy is not permittted to accept medication		time a week for four (4) weeks, and then as needed to ensure that medications are being disposed of properly and timely. Results to be reviewed at monthly QI meetings for 6 months and make further recommendations based off audit results **5 By what date will the systematic changes be completed:** a Education and in-service will be provided to all clinical staff between now and concluding on 5-1-24.	

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	02/29/2024

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
	returns that have been delivered to the community. ALL destruction is performed at the community according to individual professional licensure, federal, state and local ordinance. Utilizing the 'destruction of medication' log as provided by the community."			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (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 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 interview and record review, the facility failed to ensure a transfer form included the necessary information for a resident who was transferred to a local hospital for 1 of 2 residents reviewed for closed records. (Resident G) Findings include: The clinical record for Resident G was reviewed on 2/27/24. Resident G's diagnoses included, but not limited to, hypertension, diabetes type II, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and Rheumatoid arthritis.	R 0354	R354 **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**	05/01/2024

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	02/29/2024

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
	A transitition out note dated 2/3/24 indicated, Resident G went to the local hospital emergency room at 2 p.m. The reason indicated, wound/rash. The clinical record for Resident G did not indicate what/if any documents were sent with Resident G to the hospital. A transition note dated 2/14/24 indicated, Resident G had expired and was discharged from the facility. An interview with LPN (Licensed Practical Nurse) 9 and QMA (Qualified Medication Assistant) 8 was conducted in the nursing station on 2/29/24 at 1:14 p.m. They indicated, when a resident was sent out to the hospital, the following items are to be done/sent with them: current set of vitals, call family and notify them of the transfer, inform the DON (Director of Nursing), call the ambulance service for transport, complete a transition out note in the resident's clinical record, and print out the "Emergency printout" page. A review of Resident G's "Emergency printout" page was conducted on 2/28/24. Resident G's "Emergency Printout" contained the following information: Resident G's full name; facility name and contact information; vaccinations; diagnoses; allergies; insurance; providers name and phone number; emergency contact name and phone numbers; and preferred hospital. It did not contain: current medications, treatment orders, current vital signs, personal property when transferred to an acute care facility, nursing notes relating to resident's: functional abilities, physical limitations, or condition on transfer. According to the ED (Executive Director), the facility was unable to produce a policy/procedure		a All residents had the potential to be affected by the alleged deficient practice. Nursing staff will be educated on appropriate forms and documentation related to transfers. DON or designee will do transfer audit of all residents who go out to ensure all proper documentation is listed on the resident's face sheet (emergency printout), and transfer from is complete. **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 An audit of all transfers will be conducted by the DON or designee. Any clinical staff member out of compliance with facility's policies and protocols relating to proper 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 recording 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:**	

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	02/29/2024

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
	on transferring a resident to the hospital policy and instead referred to their discharge policy. A Discharge policy received on 2/29/24 at 1:33 p.m. from ED indicated, " When a transfer or discharge of a Resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the community. Substantiated reasons for discharge include: A. When a transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the facility... When the community proposes to transfer or discharge a resident under any of the circumstances, the resident's clinical records must be documented. The documentation must be made by the following: A. The resident's physician when transfer or discharge is necessary due to the resident's welfare and the resident's needs cannot be met... Before an interfacility transfer or discharge occurs, the community must, on a form prescribed by the department, do the following...include in the notice: i. The reason for transfer or discharge ii. The effective date of the transfer or discharge iii. The location to which the resident is transferred or discharged. A statement in not smaller than 12-point bold type that reads 'You have the right to appeal the health facility's decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice... iv. The name of the director and the address, telephone number and hours of operation of the division.... A notice of transfer or discharge must be made by		a The Director of Nursing or designee will audit each transfer as it occurs for for two (2) months, then every other month for twelve (12) months, and then as needed to ensure that all proper information is being properly reflected on the face sheet and transfer form. 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 be provided to all clinical staff between now and concluding on 5-1-24.	

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	02/29/2024

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
	the community at lease thirty (30) days before the resident is transferred or discharged. Unless the notice ust[sic, must] be made as soon as practicable in the following instances...an immediate transfer or discharge is required by the resident's urgent medical needs..."			
R 0357 Bldg. 00	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review, the facility failed to ensure if a death of a resident occurs, information concerning the resident's death included notification of the physician; personal possessions and medications; and a complete and accurate notation of the resident's condition and most recent vital signs and symptoms proceeding death for 1 of 2 closed records reviewed. (Resident G) Findings include: The clinical record for Resident G was reviewed on 2/27/24. Resident G's diagnoses included, but not limited to, hypertension, diabetes type II, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and Rheumatoid arthritis. A transition out note dated 2/3/24 indicated, Resident G went to the local hospital emergency	R 0357	R357 **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 had the potential to be affected by the alleged deficient practice. Nursing staff will be educated on proper procedures in the event of a resident death. Including, but not limited to notifying the physician,	05/01/2024

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	02/29/2024

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
	room at 2 p.m. The reason indicated, wound/rash. The clinical record for Resident G did not indicate a reason for death, the notification of the physician; personal possessions or medications at the facility; vital signs when sent to hospital; the condition of the resident at time of transfer and any signs/symptoms. A transition note dated 2/14/24 indicated, Resident G had expired and was discharged from the facility. An interview with DON (Director of Nursing) conducted on 2/27/24 at 3:58 p.m. indicated, the facility was unaware of the reason for Resident G's death but stated, it was the resident's daughter who informed the facility of her death.		properly destroying medications, contacting family regarding personal belongings and proper transitoning out of the EMAR with a detailed note. DON or designee will do a discharge audit of all residents who have expired to ensure all proper procedures have been followed. **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 An audit of all death discharges will be conducted by the DON or designee. Any clinical staff member out of compliance with facility's policies and protocols relating to proper 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 recording 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	

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	02/29/2024

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
			designee will audit each death discharge as it occurs for two (2) months, then every other month for twelve (12) months, and then as needed to ensure that all proper information is being properly reflected on the face sheet and transfer form. 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 be provided to all clinical staff between now and concluding on 5-1-24.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to have an infection control program in place that included a system to analyze and track	R 0407	R407 **1 What Corrective action(s)**	05/01/2024

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	02/29/2024

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
	infections in the facility for 108 of 108 residents in the facility. Findings include: The Infection Prevention & Control policy was provided by the Administrator on 2/27/24 at 2:20 p.m. It indicated the purpose of the policy was to minimize the risk of transmission of infection to staff members and residents. It did not include a system that enabled the facility to analyze and track infections. An interview was conducted with the DON (Director of Nursing) on 2/28/24 at 2:55 p.m. He indicated he was in charge of the facility's infection control program. If the facility did have a process in place for analyzing and tracking infections, he hadn't been updated on that process. They did not have a binder they kept to track infections on a map or to keep computer generated reports of residents' infections or those on an antibiotic. He began working at the facility in October, 2024. They inserviced on infection control when the need arose, but he hadn't inserviced on infection control specifically since he'd been there. He was unsure if infection control was part of new employee orientation. He was unable to provide any documentation they were tracking or analyzing infections in the facility, but he could print out a report of which residents were on antibiotics, but he hadn't been doing that. On 2/29/24 at 3:06 p.m., the DON provided lists of residents who were on antibiotic medication in January, 2024 and December, 2023. The lists included 7 residents with the name of the antibiotic medication, but not the diagnoses associated with the medication.		**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 an infection control program to analyze and track infections within the community, had the potential to be affected by the alleged deficient practice. RDCS will provide re-education to the DON and ADON on procedures of proper infection control tracking. Employees found to be out of compliance with proper infection control tracking 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:** a DON and ADON will be re-educated and in-serviced on the infection control policy and proper procedure to track infection control, no later than **5-1-24**. Any clinical staff member out of compliance with facility's policies and protocols relating to infection	

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	02/29/2024

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
	On 2/29/24 at 4:38 p.m., the DON provided an email from their pharmacy that included a diagnosis for 2 of the 7 residents, but no diagnoses for the other 5 residents.		control will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to infection control tracking 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 the infection control binder weekly, for 6 weeks and then monthly thereafter, to ensure that proper infection control tracking is being executed. Results to be reviewed at monthly QI meetings for 6 months and make further recommendations based off audit results **5 By what date will the systematic changes be completed** a Education and in-service will be provided to the DON and ADON between now and concluding on 5-1-24.	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for			

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	02/29/2024

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
	which hand washing is indicated by accepted professional practice. Based on observation and record review, the facility failed to ensure staff wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice during medication administration for 3 of 5 medication administrations observed. (Residents 12, 25, and 2) Findings include: A medication administration observation was conducted with QMA (Qualified Medication Assistant) 7 on 2/28/24 starting at 11:09 a.m. Upon entrance into the nursing station, QMA 7 had all the "noon" meds pulled for her residents. She had placed the pill pouches, med cups, and water cups into a large plastic bag which was sitting on the counter in the nursing station. QMA 7 picked up the large plastic bag and headed to Resident 12's room first. QMA 7 knocked on the Resident's door then used her keys to enter Resident 12's room. Once inside, without performing hand hygiene, she took out a medication cup, a water cup and the pill packet from the plastic bag. QMA 7 opened the pill packet and placed medications in cup; got water from the resident's kitchen sink; and handed the cups to Resident 12. After Resident 12 placed the medications into her mouth, QMA 7 turned around, grabbed her plastic bag and left the resident's room. After exiting the room, she did not perform hand hygiene but rather proceeded on to the next resident. QMA 7 administered medications to Resident 43 in the hallway, near the nursing station. She grabbed out the of plastic bag, a medication cup, a	R 0414	R414 **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 staff proper hand hygiene before providing care, had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all medical staff on procedures of appropriate hand hygiene. Employees found to be out of compliance with hand hygiene 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:** a All clinical staff will be re-educated and in-serviced on the hand hygiene policy no later than **5-1-24**. Any clinical staff member out of compliance with facility's	05/01/2024

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	02/29/2024

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
	water cup and Resident 43's pill packet. She realized, Resident 43 had no water, she grabbed the supplies and the plastic bag and came back with a cup of water. She then prepped the medications and handed the med cup to Resident 43. After giving Resident 43 his medications, QMA 7 did not perform hand hygiene. QMA 7 then went into the common area near the doors to the residents' smoking area. QMA 7 grabbed a med cup, a water cup and Resident 25's pill packet out of the large plastic bag. She prepped the pills and used the sink in the common area to fill a cup with water. She then walked out side to administer the medications to Resident 25. She had not performed hand hygiene prior to prepping and/or administering Resident 25's medications. After leaving Resident 25, QMA 7 administered medications to Resident 38 in the therapy room. She prepped the medication as she had in the previous administrations and after administering medications to Resident 38, she did not perform hand hygiene. Once the last medication administration was completed, QMA 7 proceeded to where Resident 2 was sitting in her wheelchair outside the nursing station near the elevator. She then without performing hand hygiene, pulled the medication cup, the water cup and Resident 2's pill packet out of the large plastic bag. QMA 7 then prepped the medications and handed the medication cup and the water cup to Resident 2. The Center for Diseases and Control (CDC) website at https://www.cdc.gov/handhygiene/providers/guideline.html, Hand Hygiene in Healthcare Settings,		policies and protocols relating to hand hygiene will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to hand hygiene 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 appropriate hand hygiene two (2) times per week for eight (8) weeks, then one (1) time a week for four (4) weeks, then two (2) times a month for one (1) month and then as needed to ensure that proper hand hygiene is being executed. 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 be provided to all clinical staff between now and concluding on 5-1-24.	

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	02/29/2024

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
	last accessed 3/4/24, indicated, "Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices Before moving from work on a soiled body site to a clean body site on the same patient After touching a patient or the patient ' s immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered."			
R 9999 Bldg. 00	Based on interview and record review, the facility failed to report follow-up to an abuse investigation to the IDOH (Indiana Department of Health) for 1 of 2 closed records reviewed. (Resident L) Findings include: On 2/27/23 at 3:30 p.m., the Administrator provided the 1/18/24 incident report for Resident L. It read, "At approximately 1:45 AM staff called	R 9999	9999 **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**	05/01/2024

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	02/29/2024

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
	and reported that [name of Resident L] was physically assaulted by a visitor in her room. The visitor also took [name of Resident L's] phone and keys and locked her in the resident's closet. Resident was able to escape out of her closet and reported the incident to nursing staff."The type of injury was a hematoma to her forehead, a contusion to her left outer eye and under her left eye. The immediate action taken was that Resident L was immediately assessed and examined by nursing staff for injuries, and the police wee immediately called. Resident L was also sent to the hospital for further evaluation. Preventive measures taken were that her entry door lock would be changed, and staff would be on the look out for the visitor in question and were alerted to call the police if this person was identified in the building. The follow-up section of the incident report was not completed. An interview was conducted with the Administrator on 2/28/24 at 1:49 p.m. He indicated there was no investigative file for the 1/18/24 incident report involving Resident L. Resident L ended up discharging home on 2/12/24. He did not report follow up on this incident to the IDOH until today, because he noticed it wasn't done. He usually tried to do the follow up within 5 days, but sometimes he forgot. He knew he was supposed to report follow up to IDOH in 5 days, because it was part of the regulation. The Abuse, Neglect, and Financial Exploitation Prevention policy was provided by the DON on 2/27/24 at 3:20 p.m. It did not reference reporting to the IDOH. This Residential Tag relates to Complaint IN00426449.		**the same deficient practice and what corrective will be taken** a N/A **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 An in-service will be held by RDO on reporting timely follow-ups for all reportables. **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 RDO will monitor weekly for 6 weeks to ensure that all reportables have timely follow-ups. **5 By what date will the systematic changes be completed** a Education and in-service will be provided by 5-1-24.	