PRINTED: 10/16/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> CO		COMPLETED	
			B. WING			
			CTREET	A DEDUCAC COMMA CITATE THE COD	09/19/2023	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
OASIS A	T ESTU			/EST 56TH STREET IAPOLIS, IN 46254		
UASIS A	1 30111		INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
R 0000						
Bldg. 00						
			R 0000			
		he Investigation of Complaint				
	IN00417452.					
		7452 - State deficiencies related				
	to the allegations as	re cited at R0091.				
	Survey date: Septer	mber 19, 2023				
	Facility number: 01	14279				
	D 11 11 G	122				
	Residential Census	: 123				
	TEL CLADE	2' 1 E' 1' '2' 1'				
	These State Residential Findings are cited in					
	accordance with 410 IAC 16.2-5.					
	Ouglity rovious con	npleted on September 22, 2023				
	Quality leview con	ipieted on September 22, 2023				
R 0091	410 IAC 16.2-5-1	3(h)(1-4)				
	Administration an	,				
Bldg. 00	Noncompliance	a Management -				
2.49.00	•	all establish and implement				
		anual to ensure that				
		facility objectives are				
	attained, to includ					
	(1) The range of s					
	(2) Residents' rigi					
	(3) Personnel adr					
	(4) Facility operat					
	· ,	be made available to				
	residents upon re					
	•		R 0091	R091	12/01/2023	
	Based on interview	and record review, the facility		Plan of Correction: Facility 01	4279	
		"Elopement Risk and Missing		Survey Event ID: CHQR11		
	Resident Policy" w	as implemented when Resident				
		n their apartment with		1 What Corrective action(s	s)	
	medications being	left in their apartment the		will be accomplished for tho	se	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE	(X6) DATE	
Lily Price			Executiv	e Director	10/06/2023	

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

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NAME OF PROVIDER OR SUPPLIER OASIS AT 56TH (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION evening prior without confirming administration of such, not being located in their apartment the following morning, and later being located at a friend's house by Guardian 3 for 1 of 1 resident reviewed for leave of absence. The clinical record for Resident B was reviewed on 9/19/23 at 2:30 p.m. The diagnoses included, but were not limited to, bipolar disorder, dementia, hypertension, hallucinations, and mood disorder. STREET ADDRESS, CITY, STATE, ZIP COD 4940 WEST 56TH STREET INDIANAPOLIS, IN 46254 ID PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CACH CORRECTION SHOULD B
OASIS AT 56TH (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION evening prior without confirming administration of such, not being located in their apartment the following morning, and later being located at a friend's house by Guardian 3 for 1 of 1 resident reviewed for leave of absence. The clinical record for Resident B was reviewed on 9/19/23 at 2:30 p.m. The diagnoses included, but were not limited to, bipolar disorder, dementia, 1D PROVIDERS PLAN OF CORRECTION (X5) COMPLETION DATE 1D PROVIDERS PLAN OF CORRECTION SIGULD BE (CROSS-REFERENCE DIO THE APPROPRIATE DEFICIENCY) DATE 1 PROVIDERS PLAN OF CORRECTION SIGULD BE (CROSS-REFERENCE DIO THE APPROPRIATE DEFICIENCY) DATE 1 PROVIDERS PLAN OF CORRECTION (X5) COMPLETION DATE 1 PREFIX FREET INDIANAPOLIS, IN 46254 1 IN DIANAPOLIS, IN 46254 2 IN DIANAPOLIS, IN 46254 2 IN DIANAPOLIS, IN 46
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such, not being located in their apartment the following morning, and later being located at a friend's house by Guardian 3 for 1 of 1 resident reviewed for leave of absence. a All residents have the potential to be affected by the alleged deficient practice. No other residents were affected. The clinical record for Resident B was reviewed on 9/19/23 at 2:30 p.m. The diagnoses included, but were not limited to, bipolar disorder, dementia, affected by the deficient practice a All residents have the potential to be affected by the alleged deficient practice. No other residents were affected.
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but were not limited to, bipolar disorder, dementia, identify other residents having
in potential to be directed by
the same deficient practice and
A SLUM (Saint Louis University Mental Status) what corrective will be taken
assessment, dated 6/5/23, indicated mild
neurocognitive disorder. a The Executive Director/DON
will meet with staff to educate on
An interview conducted with Guardian 3, on implementation of Elopement Risk
9/19/23 at 1:11 p.m., indicated she went to the and Missing Resident Policy when
facility, on 7/11/23, in the morning to take a resident cannot be located.
Resident B to a doctor's appointment. She was not b Executive Director/Designee
in her apartment. She had never been gone will educate residents at resident
overnight before and she wasn't aware of council to express the importance
Resident B leaving the facility. She had been at of signing out/notifying staff
the facility for 1 and a half years and never went member when they are leaving the
anywhere overnight. Resident B doesn't have a facility.
phone so there was no way to contact anyone.
There was a package of medications that were 3 What measures will be put
dated for 8:00 p.m. the evening of 7/10/23. So, it into place or what systemic
appeared she didn't receive her medication the changes will the facility make
night prior. She left to check at Resident B's to ensure that the deficient
friend's house, and she was there and stayed overnight at her friend's house. She knows of
Resident B's friend but was not made aware that she was leaving to stay somewhere overnight. a All staff will be in-serviced on Elopement Risk and Missing
Resident B then went to the doctor's appointment, Resident Policy.
and returned in the afternoon on 7/11/23. So, she b All new staff will be
went without her medications for the night of went without her medications for the night of in-serviced on Elopement Risk and
7/10/23 into the morning of 7/11/23. When they Missing Resident Policy before
returned to the facility, on 7/11/23 in the working independently.

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/19/2023		
NAME OF PROVIDER OR SUPPLIER OASIS AT 56TH		STREET ADDRESS, CITY, STATE, ZIP COD 4940 WEST 56TH STREET INDIANAPOLIS, IN 46254				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
IAU	afternoon, there was a male resident in her apartment, and he was holding onto the package of medications. This made Guardian 3 concerned about someone having the potential to take Resident B's medication. She took a picture of the package after she noticed such. There was an attachment of a picture of what appeared to be a prepackaged bag that had Resident B's name, instructions to take on 7/10/2023 at 8:00 p.m., listed benztropine mesylate 0.5 milligram tablet (medication for tremors), and melatonin 5 milligram tablet. The bag appeared intact and not opened to where a white, round pill was located inside the bag. Resident B's service plan, updated on 3/18/23, indicated Resident B had an unsteady gait, needed assistance with medication administration by a licensed nurse and/or qualified medication assistant (QMA), and ambulated and moved independently. The electronic medication administration record (EMAR) for July of 2023, indicated Resident B's 8:00 p.m. medications were signed off, as administered, on 7/10/23. The 8:00 a.m. medications for 7/11/23 were marked as "other" and indicated Resident B was on a "Loa (leave of absence)". This was signed off by QMA 4. An interview conducted with the Director of Nursing (DON), on 9/19/23 at 1:57 p.m., indicated she was not in the facility when this happened, but she came in later in the day on 7/11/23. Resident B's guardian came in and stated to our marketing person that Resident B wasn't there. The DON asked the staff to check Resident B's apartment and Resident B's companion's room.	IAG	4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what qualit assurance program will be pinto place: a This process will be revie by ED/designee on a weekly be for 8 weeks, monthly for 4 monand as needed thereafter as profithe QA process. b Results will be reviewed a part of the QA process in order identify any anomalies or poter patterns. If indicated, an action plan will be implemented by Coteam and reviewed as needed resolved. 5 By what date will the systematic changes be completed: 12/1/23	wed pasis enths part as er to ential enths		
	Resident B's companion (Resident F) stated that					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 B. WING		COMPLETED 09/19/2023		
NAME OF PROVIDER OR SUPPLIER OASIS AT 56TH		STREET ADDRESS, CITY, STATE, ZIP COD 4940 WEST 56TH STREET INDIANAPOLIS, IN 46254				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Resident B left with her friend and Resident B		ID PREFIX TAG	PREFIX PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(5) ETION TE
	would be right back she arrived at the fa with the guardian. V companion, Resider just left with her frie An interview condu Director (ED), on 9 she spoke with the C working the evening on how QMA 5 did	DON indicated by the time cility Resident B had returned When we spoke with the at F, he stated Resident B had end that morning on 7/11/23. Ceted with the Executive /19/23 at 3:50 p.m. She indicated QMA (QMA 5) that was g of 7/10/23. She commented not recall that evening. The				
	An interview with C at 3:55 p.m., indicat Resident B morning Resident B was not went there twice in medications for Resboyfriend" there each B was "not here". Q B the morning of 7/her guardian later of Resident B stayed v 4 indicated she was	QMA 4, conducted on 9/19/23 and seed she attempted to give a medications on 7/11/23 and located in her apartment. She attempt to administer morning ident B and there was "her ch time and indicated Resident MA 4 had not seen Resident 11/23. Resident B returned with a 7/11/23. The guardian stated with her sister overnight. QMA not aware of Resident B to be found when she				
	reviewed and did no missing medications in her apartment, or locate Resident B wapartment. A policy titled "Elo Resident Policy", re	on Log" for Resident B was of indicate anything regarding s, Resident B not being located if there were any attempts to then she wasn't found in her perment Risk and Missing evised 02/2023, was provided 23 at 3:27 p.m. The policy				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPL		
			B. WING 09/19/2023				/2023	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD EST 56TH STREET			
OASIS AT 56TH				INDIANAPOLIS, IN 46254				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	indicated the follow	_						
		en a resident is suspected to be						
		ic, escalating search will be						
	initiated to locate the person. Upon locating the							
	resident, methodical follow up will occur							
	considering the health, safety, and wellbeing of all							
	residents in the CommunityWhen it becomes							
	clear that a resident is suspected to be missing							
	from the Community, it is vital that all the members							
	of Community team follow a clearly defined							
	procedure. The following actions are a guideline							
	to help produce an organized and timely							
	responseSuspected Missing ResidentB.							
	Review Internal Documents & Resident Contact							
	Information1. The incident leader, or designee,							
	will review any notes in the electronic medical							
	record and the Resident Sign Out & In Log2. If							
	the resident has a cell phone, the incident leader,							
or designee, will call the cell phone3. Immediate								
	Search"							
	This state tag relate	s to Complaint IN00417452.						

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