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	09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00417452. Complaint IN00417452 - State deficiencies related to the allegations are cited at R0091. Survey date: September 19, 2023 Facility number: 014279 Residential Census: 123 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 22, 2023	R 0000		
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 ensure the "Elopement Risk and Missing Resident Policy" was implemented when Resident B was not located in their apartment with medications being left in their apartment the	R 0091	R091 Plan of Correction: Facility 014279 Survey Event ID: CHQR11 **1 What Corrective action(s) will be accomplished for those**	12/01/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lily Price	Executive Director	10/06/2023

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	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. Findings include: 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. A SLUM (Saint Louis University Mental Status) assessment, dated 6/5/23, indicated mild neurocognitive disorder. An interview conducted with Guardian 3, on 9/19/23 at 1:11 p.m., indicated she went to the facility, on 7/11/23, in the morning to take Resident B to a doctor's appointment. She was not in her apartment. She had never been gone overnight before and she wasn't aware of Resident B leaving the facility. She had been at the facility for 1 and a half years and never went anywhere overnight. Resident B doesn't have a phone so there was no way to contact anyone. There was a package of medications that were dated for 8:00 p.m. the evening of 7/10/23. So, it appeared she didn't receive her medication the night prior. She left to check at Resident B's 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. Resident B then went to the doctor's appointment, and returned in the afternoon on 7/11/23. So, she went without her medications for the night of 7/10/23 into the morning of 7/11/23. When they returned to the facility, on 7/11/23 in the		**residents found to have been affected by the deficient practice** a All residents have the potential to be affected by the alleged deficient practice. No other residents were affected. **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 The Executive Director/DON will meet with staff to educate on implementation of Elopement Risk and Missing Resident Policy when a resident cannot be located. b Executive Director/Designee will educate residents at resident council to express the importance of signing out/notifying staff member when they are leaving the facility. **3 What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** a All staff will be in-serviced on Elopement Risk and Missing Resident Policy. b All new staff will be in-serviced on Elopement Risk and Missing Resident Policy before working independently.	

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	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. Resident B's companion (Resident F) stated that		**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 This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date will the systematic changes be completed: 12/1/23**	

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	Resident B left with her friend and Resident B would be right back. DON indicated by the time she arrived at the facility Resident B had returned with the guardian. When we spoke with the companion, Resident F, he stated Resident B had just left with her friend that morning on 7/11/23. An interview conducted with the Executive Director (ED), on 9/19/23 at 3:50 p.m. She indicated she spoke with the QMA (QMA 5) that was working the evening of 7/10/23. She commented on how QMA 5 did not recall that evening. The staff attempted to speak to Resident F, and he wasn't able to recall the day of 7/11/23. An interview with QMA 4, conducted on 9/19/23 at 3:55 p.m., indicated she attempted to give Resident B morning medications on 7/11/23 and Resident B was not located in her apartment. She went there twice in attempt to administer morning medications for Resident B and there was "her boyfriend" there each time and indicated Resident B was "not here". QMA 4 had not seen Resident B the morning of 7/11/23. Resident B returned with her guardian later on 7/11/23. The guardian stated Resident B stayed with her sister overnight. QMA 4 indicated she was not aware of Resident B missing or not able to be found when she interacted with the previous shift. The "Communication Log" for Resident B was reviewed and did not indicate anything regarding missing medications, Resident B not being located in her apartment, or if there were any attempts to locate Resident B when she wasn't found in her apartment. A policy titled "Elopement Risk and Missing Resident Policy", revised 02/2023, was provided by the ED on 9/19/23 at 3:27 p.m. The policy			

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	indicated the following, "...ALL Communities...When a resident is suspected to be missing a systematic, 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 Community...When 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 response...Suspected Missing Resident...B. Review Internal Documents & Resident Contact Information...1. The incident leader, or designee, will review any notes in the electronic medical record and the Resident Sign Out & In Log...2. If the resident has a cell phone, the incident leader, or designee, will call the cell phone...3. Immediate Search...." This state tag relates to Complaint IN00417452.			