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	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS ASSISTED LIVING, INC	4301 WASHINGTON AVE EVANSVILLE, IN 47714

(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 IN00425761. Complaint IN00425761: State deficiencies related to the allegation(s) are cited at R0052 Survey date: January 10, 2024 Facility number: 013613 Census Bed Type: Residential: 64 Total: 64 Census Payor Type: Medicaid: 29 Other: 35 Total: 64 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 18, 2024.	R 0000	The Following Plan of Correction for Oasis Assisted Living regarding the statement of deficiencies dated January 10, 2024. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to the delivery of the best quality health care services and will continue to make changes and improvements to satisfy that objective. The facility is also requesting desk review for compliance in these areas.	
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 interview and record review, the facility failed to protect the resident's right to be free from	R 0052	1. What corrective action(s) will be accomplished for those residents found to have been affected by the	02/29/2024

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

Brandi Huffman | Administrator | 01/30/2024

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

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	neglect for 1 of 3 residents reviewed for wandering. The facility did not provide monitoring and assistance per the plan of care for a resident with a history of wandering. A resident exited the facility into a gated courtyard while unobserved and went unaccounted for in the cold and rain for approximately 6 hours, resulting in an unwitnessed fall and requiring hospitalization for treatment of hypothermia. (Resident F) Finding includes: During a review of facility reported incident on 1/10/24 at 10:15 A.M., an incident report dated, 1/9/24, indicated Resident F was noticed to be missing during a routine bed check at 1:00 A.M. A search concluded when the resident was found outside in the facility courtyard. The resident was sent to the emergency department for evaluation and treatment. During record review on 1/10/24 at 10:40 A.M., Resident F's diagnoses included, but were not limited to, Alzheimer's dementia, depression, and diabetes mellitus. Resident F's plan of care included but was not limited to; wandergaurd check (started 11/8/23), Toileting - Resident is incontinent of bowel and bladder, needs directional assistance to find the nearest bathroom when not in apartment every two hours (started 11/8/23), and staff to monitor for signs of anxiety and agitation. Resident to remain in line-of-sight supervision when displaying behaviors to prevent the occurrence of altercations with peers. Resident F's nurse's notes included, but were not limited to: 1/9/24 at 2:13 A.M. - At approximately 1:20 A.M.,		deficient practice? To ensure the psycho-social well-being and prevent future occurrence and deficient practices of staff not following the plan of care and proper monitoring of residents who display wandering behavior the facility will audit all care plans to ensure all residents with a history of wandering are care planned and have a 2-hour monitoring schedule in place. 2. How will you identify other residents having potential to be affected by the same deficient practice? All residents have the potential to be affected by the same deficient practice systematic changes are as follows: All staff will be trained on Abuse policy, prevention, resident care plans, and documentation including the 3rd shift visual checks. All courtyard doors have had keypad code locks placed on them to ensure that all residents can only gain access to the courtyards during inclement weather by a staff member inputting the code and escorting them into the enclosed courtyard. 3. What measures will be put into place or what systematic changes will make you to ensure the deficient practice does not	

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	CNA noted resident not in her bed or apartment. Staff began room to room search and then a second search. During second search CNA noted someone out in the gated courtyard. All staff immediately responded. Resident found lying on back in courtyard. Blankets immediately applied for warming and 911 called along with Facility Administrator. Resident transferred by ambulance to emergency room (ER). A facility investigation included a typed statement signed by the Facility Administrator and dated 1/10/24. The statement included, "At 1:46 A.M. on 1/9/24 Administrator received a call (from LPN 5) that they had found (Resident F) in the courtyard at 1:45 A.M. (Resident F) had abrasions to her face and knees upon assessment from an unwitnessed fall. Nurse stated the resident skin was cold to touch and that she had called 911 to send the resident of [sic] further evaluation and treatment... Cameras were reviewed to establish a timeline of events. Resident was seen wandering around the unit after supper. The resident was last seen on camera at 7:40 P.M. in Gigi's Kitchen exiting into the enclosed courtyard. Resident was not seen on camera again inside the unit until EMS (Emergency Medical Service) arrived. Due to the heavy rain the cameras in the enclosed courtyard were covered in water droplets and the recorded footage was too distorted to discern any information... ER called at approximately 3:00 A.M. notifying us the resident was stable and also being treated for a UTI (urinary tract infection). (Resident F was) given warm Saline via IV (intravenous) to warm the resident..." Resident F's ER physician examination records, dated 1/9/24 at 2:28 A.M., included that the resident presented in the ER profoundly		recur? All Employees will be informed upon hire and trained at least quarterly thereafter of their responsibility to intervene when seeing deficient practices to prevent harm to all residents and to report immediately to their supervisor, actual and/or suspected incidents of resident mistreatment, neglect, physical, sexual, verbal, or mental abuse, or misappropriation of resident property to the Administrator/designee. All staff will be trained upon hire and at least quarterly thereafter on resident care plans and documentation to ensure proper monitoring practices are in place. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The administrator/designee will complete an audit of all resident care plans and monitoring schedules that are in place for those with a history of wandering. A checklist will be completed nightly on 3rd shift of visual verification for all residents residing on the dementia unit that they are safe within the unit. A checklist of required documentation has been completed daily for all current residents. A care plan audit will be completed monthly for 6 months	

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	hypothermic, Resident F's core body temperature was 84.2 degrees Fahrenheit, the resident's general appearance included shivering and moaning. Physician to admit resident to Intensive Care Unit (ICU) due to requiring "active rewarming with bear hugger." Evansville weather and temperature on 1/8/24 at 7:54 P.M. thru 1/9/24 at 1:54 A.M. were recorded as rain to heavy rain and ranged from 42 - 41 degrees Fahrenheit according to the National Weather Service at weather.gov/data/obhistory/KEVV.html. During an interview on 1/10/24 at 10:05 A.M., QMA 8 indicated that all residents on the locked dementia unit should be accounted for at all times and each resident should be checked on at least every two hours. During an interview on 1/10/23 at 11:45 P.M., the DON (Director of Nursing) indicated that all residents should be checked on at least every two hours "around the clock." On 1/10/24 at 1:25 P.M., the Facility Administrator supplied a facility policy titled Wander Alert System, dated 3/2016. The policy included, "...the wander alert system is considered an additional safety precaution and is not designed to be used in place of a "dementia special secure unit" within the home..." This citation relates to complaint IN00425761.		to ensure the deficient practices does not recur. Date of Compliance: February 29, 2024	