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	03/10/2023

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

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R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the State Residential License Survey and the PSR to the Investigation of Complaint IN00397134 completed on 12/20/22. This visit was in conjunction with a PSR to the Intestigation of Complaint IN00400056 completed on 1/31/23. Complaint IN00397134 - corrected. Complaint IN00400056 - corrected. Survey dates: March 10, 2023 Facility number: 013347 Residential Census: 105 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 14, 2023	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michele Simoneaux	RDHS	03/31/2023

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

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	fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a minimum of one awake staff person with current CPR (cardiopulmonary resuscitation) and first aid certificates were on site at all times for 105 of 105 residents who reside at the facility. Findings include: The facility's staffing schedule, as worked, for the time period of 2/12/23 through 2/18/23 and the current CPR and first aid certificates for staff were provided by ED on 3/10/23 at 11:30 a.m. Upon cross referencing the provided staffing schedule with the certificates, the facility did not have a staff member with current CPR and/or first aid certification on the following dates and shifts: 2/12/23 evening and night shifts, 2/13/23 night shift, 2/14/23 night shift, 2/15/23 night shift, 2/16/23 evening and night shifts, 2/17/23 night shift, and 2/18/23 day, evening, and night shifts. An interview was conducted with the BOM (Business Office Manager) on 3/10/23 at 1:15 p.m. She indicated she was unaware there was a time frame for scheduling first aid classes for staff and	R 0117	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. No residents experienced 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 what corrective will be taken** 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. **4. How the corrective action(s) will be monitored to ensure the deficient practice**	04/10/2023

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	had the classes scheduled to be completed on 3/14/23 and 3/16/23. She was unable to provide verification of a staff person with a CPR and a first aid certificate who worked the above mentioned shifts. This deficiency was cited on 12/20/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		**will not recur, i.e what quality assurance program will be put into place:** a. **5. By what date will the systematic changes be completed** a. Completion of current nursing staff CPR/First Aid training by 04/10/2023.	
R 0327 Bldg. 00	410 IAC 16.2-5-7.1(b) Activities Programs - Nonconformance (b) The facility shall provide and/or coordinate scheduled transportation to community-based activities. Based on interview and record review the facility failed to provide outside activities, as preferenced, to 5 of 9 residents reviewed for activity participation. (Residents B, G, H, L, and Z) Findings include: 1. The clinical record for Resident B was reviewed on 12/16/22 at 3:00 p.m. and 3/10/23 at 11:19 a.m. The diagnoses for Resident B included, but were not limited to, hypertension. She was admitted to the facility on 3/14/22. The 9/30/22 Level of Service Assessment/Evaluation indicated Resident B was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed, but may miss some part or intent of the message.	R 0327	**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. Activities Director or designee will schedule outings, no less than once per month, place outing on distributed calendar, and coordinate the use of Gardant sister facility bus to complete scheduled outings.	04/10/2023

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	2. The clinical record for Resident L was reviewed on 12/20/22 at 2:00 p.m. The diagnoses for Resident L included, but were not limited to, anxiety. She was admitted to the facility on 7/1/22. The 10/5/22 Level of Service Assessment/Evaluation indicated Resident L was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed without difficulty. 3. The clinical record for Resident H was reviewed on 12/15/22 at 3:00 p.m. The diagnoses included, but were not limited to, asthma. A level of service assessment dated 9/30/22 indicated Resident H "...understands information conveyed without difficulty. Communicates information and is understood ...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." 4. The clinical record for Resident G was reviewed on 12/15/22 at 3:00 p.m. The diagnoses included, but were not limited to, hypertension. A level of service assessment dated 9/30/22 indicated Resident G "...understands information conveyed. May miss some part or intent of the message. Communicates information and is understood ...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." 5. The clinical record for Resident Z was reviewed on 12/20/22 at 1:45 p.m. The diagnoses included,		**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. Activity Director or designee will report to the facility Administrator any changes or cancellations of outing events in timely manner. Rescheduling of outing events will occur, within originally scheduled month, and will include collaboration of Administrator, Activity Director, and sister facility staff/designee. **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 Administrator or designee will receive a copy of activities calendar monthly and verify use of sister facility bus, with sister facility staff/designee, for scheduled outing dates. **5. By what date will the systematic changes be completed** a. Scheduling of outings and collaboration with sister facility will be ongoing, and implemented by 04/10/2023	

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	but were not limited to, hypertension. She was admitted to the facility on 4/26/22. The 11/28/22 Level of Service Assessment/Evaluation indicated she communicated information and was understood. She understood information conveyed without difficulty. The 6/15/22 Resident Committee Meeting Agenda/Minutes was provided by the Marketing Director on 12/16/22 at 3:22 p.m. It read, "Resident Services: Bus, still not working. How or what is needed to asst [assist] members to & from the store, or go out to see movies. Issue: The bus is being repaired per [name of previous Administrator.]" The December, 2022 activity calendar was provided by the IED (Interim Executive Director) on 12/15/22 at 2:24 p.m. It did not include any outside activities like restaurants, shopping, bowling, etc. An interview was conducted with the AD (Activity Director) on 12/16/22 at 11:12 a.m. She indicated she'd worked there since August, 2021. When she first began working, the facility bus "worked twice and that was it," within her first month there. By September, 2021, the bus no longer worked. She wanted to take the residents to see a local Christmas lights display, but they didn't have transportation for getting them there. She hadn't been able to take them shopping, to parks, restaurants, or picnics. If they had transportation, she would schedule an activity outside of the facility at least weekly. In August, 2022, they borrowed a bus from a sister facility to take residents to the state fair, but that was the last outside activity they'd had. She'd spoken to			

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	the IED a week or so ago about borrowing the bus again to take residents to the local Christmas lights display, but hadn't heard back yet. She stated, "I'm hoping to." Residents had been asking her about doing outside activities and when the bus would be ready. An interview was conducted with Resident B on 12/16/22 at 11:23 a.m. She indicated she went to the state fair in August, 2022, and that was the only outside activity the facility had. She would go on more if they had more. She would like to go to the museum, shopping, restaurants, and the park when it's warm. Sometimes she felt affected by not going out. She was told when she admitted that they had a bus for activities to take residents places. "Then to get here and find out the bus is broke down. I was like finally we get to go somewhere when we went to the fair," but they borrowed the bus. Sometimes she felt "cooped up" and wanted to get out, mostly when it was warm. An interview was conducted with Resident L on 12/19/22 at 11:58 a.m. She indicated she would like to go to outside activities, like going to the store, to the casino, bowling, and things like that "that we should be able to go to, like senior things that we can't do." An interview was conducted with Resident H on 12/19/22 at 2:15 p.m. She indicated the activity bus had not been working for 2 years, since she'd been living there. She got a local bus pass, because there was no bus to take residents to outside activities. An interview was conducted with Resident G on 12/15/22 at 2:18 p.m. She indicated the facility did not have an activity bus. She went as a guest with			

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	Resident H and used her local buss pass sometimes, as Resident H was allowed to take 1 guest with her on the bus. If Resident H did not go anywhere, she couldn't go anywhere either. She would like to go to outside activities. An interview was conducted with Resident Z on 12/19/22 at 2:21 p.m. She indicated she would love to leave for outside activities, but they hadn't had a bus since she'd been there. An interview was conducted with Resident B and Resident L on 3/10/23 at 12:15 p.m. Both residents indicated there were still no outside activities occurring through the facility. The new ED (Executive Director) attended the most recent resident council meeting and informed them they would be getting a new bus by 3/31/23 that they could use for outside activities. Now they were hearing that it wasn't in the budget and they were going to have to share a bus with a sister facility. Resident B indicated when she admitted to the facility, she was told they had transportation for things like going to the store and museums, but it still hadn't happened, and they were trying to fight for it in resident council. Resident B continued to ask the ED about the bus and was told she was working on it. An interview was conducted with the ED on 3/10/23 at 10:38 a.m. She indicated the facility bus was currently "down." They recently got permission to borrow the bus from a sister facility, and the plan was to have their bus on Tuesdays and Fridays moving forward. An interview was conducted with the ED on Friday, 3/10/23, at 12:02 p.m. She indicated when she started working at the facility in January, 2023, the regional maintenance supervisor informed her			

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	that the bus was not drivable or safe, so he parked it. She discussed the issue with her regional support and the owner to come up with a plan. She looked at leasing a bus, but it was not in the budget. They agreed to share a bus with a sister facility, which was just confirmed yesterday, 3/9/23. The plan was for them to use the sister facility's bus on Tuesdays and Fridays moving forward, starting next Tuesday, 3/14/23. No outside activities had yet occurred or been scheduled. The March, 2023 Activity Calendar was provided by the ED (Executive Director) on 3/10/23 at 11:30 a.m. It did not include any outside activities like restaurants, shopping, bowling, museums, etc. The New Resident Orientation Policy-Activities was provided by the Regional Marketing and Sales Director on 12/19/22 at 3:00 p.m. It read, "PURPOSE: The purpose of this policy is to ensure that all new residents receive an orientation pertaining to the community activities in a timely manner. POLICY: It is the purpose of the community to create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life." This deficiency was cited on 12/20/22. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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.			

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	(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 was utilized with pertinent information that included: the address to the facility the resident was being transferred to, the resident's property she had when she was transferred to an acute care facility, nurse's notes related to the functional abilities, condition of resident at the time of transfer, date of chest x-ray and skin test for tuberculosis to ensure continuity of care was provided to the receiving health care facility for 1 of 3 residents closed records reviewed. (Resident 70) Findings include: The clinical record for Resident 70 was reviewed on 3/10/23 at 11:00 a.m. The diagnosis included, but was not limited to, deafness. Transfer paperwork was provided for Resident 70, by the Director of Nursing on 3/10/23 at 1:36 p.m. The resident had discharge on 3/10/23 to the hospital. The discharge paperwork did not include the following information to be provided to the receiving health care facility: the address the facility's being transferred to, the condition of the resident at that time of transfer, chest x-ray, skin test for tuberculosis, the resident's property she	R 0354	**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 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**	04/10/2023

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	had at the time of transfer, nurse's notes related to the functional abilities. An interview was conducted with the Director of Nursing on 3/10/23 at 12:25 p.m. She indicated she was unaware of the required information needed to be provided to the receiving health care facility when a resident was discharged. This deficiency was cited on 12/20/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		**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:** 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	

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			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 April 10, 2023	