Brandi Huffman

continued program participation.

PRINTED: 03/21/2025 FORM APPROVED OMB NO. 0938-039

03/14/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> COI		(X3) DATE SURVEY COMPLETED 02/18/2025	
	PROVIDER OR SUPPLIE		4301 V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON AVE SVILLE, IN 47714	
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Survey. Survey dates: Febr Facility number: 0 Residential Census These State Reside accordance with 41 Quality review con	13613 : 61 Intial Findings are cited in 0 IAC 16.2-5. Impleted on February 21, 2025.	R 0000	The provider respectfully requal desk review with paper compliance to be considered establishing that the provider substantial compliance. Preparation or execution of the plan of correction does not constitute provider admission agreement related to the truth the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of Correction is prepared and executed solely because it is required by the position of Stataw. The Plan of Correction is submitted in response to the annual survey on February 18 2025. All facility training and corrections will be implemented or before March 16, 2025. Please accept this Plan of Correction as the provider's credible allegation of complian The provider respectfully requal desk review with paper compliance to be considered establishing that the provider substantial compliance.	in is in is or of of ons attentials. She in in is or of one of on
R 0117 Bldg. 00	failed to ensure at l duty at all times wi	• •	R 0117	R0117 Personnel - Deficiency 1. What corrective action will be accomplished for residents affected?	
LABORATOF	I RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S.	IGNATURE	TITLE	(X6) DATE

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

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Administrator

days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETER B. WING 02/18/202		LETED		
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD VASHINGTON AVE		
OASIS ASSISTED LIVING, INC				SVILLE, IN 47714		
(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
	with state laws for a certification did not certification did not Finding includes: On 2/18/25 at 11:00 for the period of 2/2 time, CPR certifications indicated in the faciliate certifications indicated though (Academy). On 2/18/25 at 11:33 Care Academy) we indicated "Do you we do not offer ham During an interview Administrative Assisted CPR certifications. During an interview Administrative Assisted CPR certifications in the course and no one lateral training. During an interview Administrative Assisted CPR certifications in the course and no one lateral training.	R LSC IDENTIFYING INFORMATION 7 of 7 days reviewed. CPR thave a hands on component. O A.M., staffing was reviewed 11/25 through 2/18/25. At that tion was provided for staff who ty during that period. The tted requirements had been Name of Health Care 5 A.M., the (Name of Health bsite was accessed and offer hands-on training? No,		To ensure the correction of deficient practice of all CP certified staff not having the on component; the facility audit all employee files to a current CPR with the har component is in place for required employees. All of employees whose position current CPR lacks the har component will be re-certification course. CPR certification course. CPR certification will be provided ongoing basis to all staff to a current CPR with hands component. The Director of Nursing has enrolled in a current CPR with hands component. The Director of Nursing has enrolled in a current CPR with hands component and upon reference to ensure the facility can be consulted to ensure the facility can be consulted to be affected to be affected by the same of practice systematic changes as follows: To ensure compliance with healthcare safety standard maintain a high level of en preparedness, a CPR certicourse was held on March 2025, at 1:00 PM for current compliance with the potential to the preparedness, a CPR certicourse was held on March 2025, at 1:00 PM for current process.	of the R we hands will ensure nds on all urrent whose ds on fication, son CPR ad on an o ensure on of CPR rse I Cross ffer in o all enewal.	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00		SURVEY LETED 5/2025
NAME OF PI	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD VASHINGTON AVE		
OASIS AS	SSISTED LIVING,	INC		SVILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
				QMA/Nurses. This training session included a hands component to reinforce paskills in life-saving interver. Ongoing certification sessible scheduled until all star members have successful completed the required recertification process. To objective of this is to enseach scheduled shift has at least one CPR-certified employee available, in all with Federal and State regulations. 3. What measures with put into place to ensure practice does not recurrent CPR certification hands on component. State cannot provide the requesterification upon hire will enrolled in a CPR certification upon hire will enrolled in a CPR certification. 4. How corrective Act will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will into place? An audit of all CPR required a current certification that State and Federal regular.	ractical entions. sions will ff ully he ure that always dignment II be this ? uired f of a with aff who sted CPR l be ation tion(s) cure the ot be put red staff for 30 s to staff have t meets	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 B. WING		COMPLETED 02/18/2025	
	PROVIDER OR SUPPLIER SSISTED LIVING, I		4301 V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON AVE SVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0407	410 IAC 16.2-5-12	(b)(1-4)		All employees will be required upon hire to provide proof of the current CPR certification with hands on component. Staff who cannot provide the requested certification upon hire will be enrolled in a CPR certification course.	heir no CPR
Bldg. 00	Infection Control -				
	failed to ensure the included orientation assess the risks or ex (TB) for staff members. Finding includes: During an interview Administrator indicates written policy within program related to the orientation of the staff policy was to follow During an interview Director of Nursing education for Tuber	on 2/18/25 at 3:33 P.M., the ated the facility did not have a nother infection control suberculosis screening, testing, if members, and the facility's at state guidelines. on 2/16/25 at 3:46 P.M., the (DON) indicated no staff culosis signs and symptoms, at risk factors, were provided	R 0407	R0407 Infection Control-Emple 1. What corrective action was be accomplished for residents affected? For all residents affected by the deficient practice an audit was completed ensure the infection control program included orientation and in-service education to assess the risks exposures of Tuberculosis (TE staff members. 2. How will the facility idented other residents having the potential to be affected by the same practice and what correlaction will be taken? All residents have the potential be affected by the same deficity practice systematic changes as as follows: For all residents affected by the deficient practice an audit was completed ensure the infection control program included orientation and in-service education to assess the risks exposures of Tuberculosis (TE)	vill ine ine in ine in

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 02/18/2025
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD /ASHINGTON AVE	
OASIS AS	SSISTED LIVING, I	NC		SVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	REGULATORT OR	LSC IDENTIFITING INFORMATION	IAU	staff members. All staff will be provided eduction upon hire and annually to asset the risks or exposures of Tuberculosis (TB) for staff members. All current staff will be provided with to education to assess the risks or exposures of Tubercul (TB) for staff members on or be March 16, 2025. 3. What measures will be printo place to ensure this practic does not recur? At the time of employment, or within one (1) month prior to employment, and at least annually thereafted employees and non-paid personnel of the facility shall be screened for tuberculosis. The first tuberculosis with test must be read prior to the employee starting work. For he care workers who have not had a document negative tuberculin skin test reduring the preceding twelve (12) more the baseline tuberculin skin testing should employee the two-step method. If the first step is negative, a second test should be perform one (1) to three (3) weeks after first step. The frequency of repeat testing will depend on the risk	ation ess d e closis pefore out ce er, iin ealth ted esult oths,
			1	Ī	i

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 B. WING		COMPLETED 02/18/2025	
	PROVIDER OR SUPPLIER SSISTED LIVING, I		4301 V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON AVE SVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				infection with tuberculosis. An employe that has had a previously documented skin test will not be required to have another skin test but mus provide documentation of a chest x-ra and annual assessments to ru out any signs or symptoms of tuberculosis. 4. How corrective Action(s) be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? An audit of all employee hire a annual TB screening will be completed weekly for 30 days then monthly for 6 months to ensure all staff have a current screening that meets State an Federal regulations.	ost y le will ; and and TB
R 0412 Bldg. 00	410 IAC 16.2-5-12 Infection Control -	• •			
	failed to ensure an a screening was comprecords reviewed. Finding includes: 1. On 2/18/25 at 11 record was reviewed.	and record review, the facility annual Tuberculosis (TB) pleted for 2 of 7 resident 208 A.M., Resident 7's clinical d. Diagnoses included, but dementia. The resident was lity on 6/23/23.	R 0412	R0412 Infection Control-Residents 1. What corrective action was be accomplished for residents affected? For all residents affected by the deficient practice an audit was completed ensure all current residents received an annual screening was completed. 2. How will the facility idention other residents having the potential to be affected by the	rill ne s

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/18/2025		
	PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 4301 WASHINGTON AVE				
UASIS A	NOOISTED LIVING,	INC	EVAIN	SVILLE, IN 47714			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(X5) COMPLETION DATE			
	The clinical record or risk assessment of 2/18/25 at 9:49 A.M. was reviewed. Diag limited to, dementing the facility on 2/26. The clinical record or risk assessment of 2/18/25 at 2:40 (DON) indicated R	lacked a Tuberculosis (TB) test during the past year.2. On M., Resident 1's clinical record gnoses included, but were not a. The resident was admitted to		same practice and what coraction will be taken? All residents have the poten be affected by the same def practice systematic changes as follows: For all residents affected by deficient practice an audit we completed to ensure the infecontrol program included an TB skin testing. In lieu of a tuberculin skin test, these pershould have an annual risk assessment for the develop of symptoms suggestive of tuberculosis, including, but relimited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-residents with a chest x-result of the develop of symptoms are present, the individual shall be evaluated immediately with a chest x-resident within three (3) in prior to admission or upon admission and read at forty-(48) to seventy-two (72) houresults shall be read in milling of induration with the date go date read and by whom administered and read. For residents who have not documented negative tuberts skin test result during the preceding twelve (12) month baseline tuberculin skin test testing should employ the	rective tial to icicient s are the as ection anual ersons ment not at d ay. e put ctice ee nonths eeight urs. The meters iven, had a culin as, the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/18/2025		
NAME OF PROVIDER OR SUPPLIER OASIS ASSISTED LIVING, INC			4301	FADDRESS, CITY, STATE, ZIP COD WASHINGTON AVE ISVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				two-step method. If the first sonegative, a second test should performed within one (1) to the (3) weeks after the first test. If frequency of repeat testing with depend on the risk of infection tuberculosis. All residents who have a positive reaction to the tuberculin skind shall be required to have a character and other physical and laboratory examinations as determined by a licensed physician to complete a diagram. How corrective Action(sone be monitored to ensure the deficient practice will not recuive, what quality assurance program will be put into place. An audit of all new admission and annual TB screening will completed weekly for 30 days then monthly for 6 months to ensure all residents have a control to the control of t	d be lifee The lill in with tive litest hest hosis) will lir, ? s be s and lurrent

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