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	12/05/2023

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

(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 Complaints IN00417348, IN00422580 and IN00423276. Complaint IN00417348. No deficiencies related to the allegations are cited. Complaint IN00422580. State deficiencies related to the allegations are cited at R053 and R153. Complaint IN00423276. No deficiencies related to the allegations are cited. Unrelated deficiency cited. Survey dates: December 4 and 5, 2023 Facility number: 013347 Residential Census: 106 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 12, 2023	R 0000		
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to ensure a resident was prevented from experiencing verbal abuse from a facility staff member for 1 of 3 residents reviewed for abuse. (Resident F) Findings include:	R 0053	Plan of Correction Facility ID: 013347 Survey Event ID: IMYS11 R053 1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	02/01/2024

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

Maurice Woolfolk | Excecutive Director | 12/24/2023

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	The clinical record of Resident F was reviewed on 12-5-23 at 12:50 p.m. Her diagnoses included, but were not limited to anxiety/panic disorder, bipolar disorder, COPD (chronic obstructive pulmonary disease) and fibromyalgia. Her most recent cognitive assessment, dated 8-7-23, indicated she displayed mild cognitive impairment. In an interview with the Executive Director on 12-4-23 at 10:30 a.m., he indicated an allegation of verbal abuse was made by Resident F in which a staff housekeeper allegedly cursed in the resident's presence during September of 2023. He provided a copy of the facility's investigation, including a report sent to the Indiana Department of Health's Long Term Care Division. This report, dated 9-18-23, indicated on the same date, Resident F had reported to the facility Housekeeper 5 had "used profanity in a conversation when she asked for her room to be cleaned." Housekeeper 5 was suspended, pending further investigation. A written statement, dated 9-19-23, from Staff Member 6 indicated Resident F "started to shout at [name of Housekeeper 5]" regarding getting her room cleaned." The statement indicated Housekeeper 5 responded to Resident F with, "I don't work for you...I don't give a f----d [sic] about your apartment." In a written statement from the Executive Director, dated 9-19-23, to a superior, it indicated his investigation demonstrated, Housekeeper 5 "admitted to saying, 'I don't give a f--k what she (the resident) thinks' while speaking to her co-workers in vicinity of the resident." An associated document, dated 9-19-23, indicated Housekeeper 5 was terminated from employment on 9-19-23, related to, "After further investigation is was confirmed that this employee engaged in what could be considered verbal abuse of a resident. Employee also violated policy 4,		a All residents had the potential to be affected. After the alleged employee was suspended during investigation the resident accusation was substantiated and the employee was terminated. 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. 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 All staff in-service on resident abuse, resident rights, including verbal abuse will be completed by 2/1/24. All new hires will receive education on resident rights and abuse policy during orientation. 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 All staff in service will be completed by 2-1-24 on resident abuse and resident rights. An abuse training audit will be completed by the Executive Director/designee to ensure every staff member has been re-educated.	

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	'Unreasonable, unsafe, discourteous or abusive treatment including the use of profanity...'" Resident F was unable to be interviewed after 3 unsuccessful attempts to locate her during the survey. On 12-5-23 at 2:42 p.m., the Executive Director provided a copy of a policy entitled, "Abuse, Neglect, and Financial Exploitation." This policy was identified as the current policy utilized by the facility and had a revision date of 2/2021. This policy indicated, "Residents of the community have the right to be free of abuse, neglect and financial exploitation. Staff will conduct themselves in a manner that is respectful and courteous at all times. Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the community...The community will make every effort to prevent abuses, neglect, or financial exploitive staff behavior through staff training. In-service education for staff will be provided at the time of hire and every six months thereafter. In-service education for staff will be provided at the time of hire and every six months thereafter..." This Residential tag relates to Complaint IN00422580. 2.5-1.2(w)		5 By what date will the systematic changes be completed: a Compliance by: 2/1/24	
R 0153 Bldg. 00	410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen.			

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	Based on interview and record review, the facility failed to ensure residents who utilize supplemental oxygen and are current smokers conduct their smoking in a safe manner for 2 of 3 residents reviewed for oxygen use. (Residents E and J) Findings include: 1. The clinical record of Resident E was reviewed on 12-5-23 at 1:25 p.m. His diagnoses included, but were not limited to, end stage renal (kidney) disease, coronary artery disease and tobacco use. He has been a resident of the facility for over two years. In an interview with Resident E on 12-5-23 at 9:35 a.m., he indicated he utilized supplemental oxygen on part-time basis only. He added he does smoke outside only and he sometimes does wear his oxygen while he is smoking, as he forgets he has the oxygen on. Resident E indicated he is aware of potential hazards of smoking in the presence of supplemental oxygen, but has never had any negative impacts. 2. The clinical record of Resident J was reviewed on 12-4-23 at 11:28 a.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease). He has been a resident of the facility for over one year. In an interview on 12-5-23 at 9:15 a.m., with Resident J, he indicated he uses supplemental oxygen on full time basis. He added he smokes outside the facility on the facility grounds and sometimes off premises and "usually just keep my oxygen on because I've never had a problem with it. I've heard it can explode, but I've never had a problem with it."	R 0153	Plan of Correction Facility ID: 013347 Survey Event ID: IMYS11 R153 1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a All residents had the potential to be affected. All residents that smoke and use oxygen will be re-educated regarding the hazards of smoking while using oxygen. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. a All residents had the potential to be affected. All residents that smoke and use oxygen are at risk as well as other residents in vicinity. All residents that use oxygen and smoke will be educated on the dangers of smoking while using oxygen. Signs have been placed in the designated smoking area reminding residents not to use oxygen while smoking. b Executive Director and Activity Director will monitor designated smoking area 2x a week for the next 3 months to ensure residents aren't smoking while using oxygen. 3 What measures will be put	04/01/2024

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	In an interview with the Executive Director on 12-5-23 at 11:40 a.m., he indicated he was unaware of any residents smoking while having oxygen on. On 12-5-23 at 1:52 p.m., the Executive Director provided a copy of a policy entitled, "Smoking and Tobacco Product Use." This policy was identified as being currently utilized by the facility and had a revision date of 2/2021. This policy indicted, "Due to the nature of our business, no employee, resident, and/or guest shall be permitted to smoke or otherwise use any smoking products in any common areas or in the Unit...Smoking and use of tobacco products are permitted in designated exterior areas; distances are determined by the communities respective state ordinances...Residents, families and visitors may smoke only in designated areas outside the building...It is the responsibility of the Administrator to determine smoking and nonsmoking areas. On 12-5-23 at 1:52 p.m., the Executive Director provided a copy of a portion of the facility's lease, with a revision date of 3/2023. This portion of the lease indicated, "No resident or guest shall be permitted to smoke or otherwise use any smoking products in any common areas or in the Units...The Owner will designate upon the exterior grounds of the Premises locations where residents may smoke, provided there are shall be no tobacco products in any instance where a safety concern exists." On 12-5-23 at 1:52 p.m., the Executive Director provided a copy of a facsimile (fax), dated 12-5-23 at 12:39 p.m., from the Regional Director of Clinical Services. This fax indicated, "We do not have a policy that mentions O2 [oxygen]. We just use the general non-smoking in the room policy.		into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: a All staff in-service will be completed by 2/1/24 to observe residents that smoke while using oxygen and to report this hazard to the Executive Director immediately. 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 Executive Director and Activity Director will monitor smoking areas 2x a week for the next 3 months to ensure residents aren't smoking while using oxygen. 5 By what date will the systematic changes be completed: a Compliance by: 4/1/24	

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	However, we can mention that if we see it we stop it. Also can mention that residents have been educated by their doctors and also the O2 company about smoking." This Residential tag relates to Complaint IN00422580. 2.5-1.5(j)			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be			

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	involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were put into place and updated at least annually for 5 of 9 residents reviewed for service plans. (Residents E, F, H, J and K) Findings include: 1. The clinical record of Resident E was reviewed on 12-5-23 at 1:25 p.m. His diagnoses included, but were not limited to, end stage renal (kidney) disease, coronary artery disease and tobacco use. He has been a resident of the facility for over two years. A review of his most recent "Level of Service Assessment/Evaluation" was dated 9-12-23. His most recent service plan indicated an initial service plan was dated 3-20-20, with an "annual," dated 10-20-21 and the most recent update listed as 10-2-22. The most recent service plan was not signed or dated by the resident and lacked documentation to suggest the resident received a copy of the service plan. 2. The clinical record of Resident F was reviewed on 12-5-23 at 12:50 p.m. Her diagnoses included, but were not limited to, anxiety/panic disorder, bipolar disorder, fibromyalgia and COPD (chronic obstructive pulmonary disease). She has been a resident of the facility for over two years. A review of his most recent "Level of Service Assessment/Evaluation" was dated 9-22-23. Her most recent service plan indicated her initial service plan was undated, with an "annual," dated 4-20-20 and the most recent update listed as 4-24-19 [sic]. The service plan in the clinical	R 0217	Plan of Correction Facility ID: 013347 Survey Event ID: IMYS11 R217 1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a Residents E, F, H, J and K have updated service plans. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. a Residents that reside at the community may be affected by the deficient practice. The Director of Nursing, Assisted Director of Nursing will be in serviced by clinical support on identifying and completing outdated service plans in the Caremerge EMR software. 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 Current residents that have had level of care plans generated or updated will have met with Director of Nursing or Assisted Director of Nursing, by date of compliance, signed and dated their service plan, and received a copy of same at their request.	04/01/2024

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	record had a staff signature date of 9-9-20. The most recent service plan was not signed or dated by the resident and lacked documentation to suggest the resident received a copy of the service plan. 3. The clinical record of Resident H was reviewed on 12-4-23 at 12:33 p.m. His diagnoses included, but were not limited to, cerebral infarction with hemiparesis, Parkinson's disease and schizophrenia. He has been a resident of the facility for over two years. A review of his most recent "Level of Service Assessment/Evaluation" was dated 11-15-23. His most recent service plan indicated an initial service plan was undated with an "annual," dated 7-19-22 and the most recent update listed as 10-4-22. The most recent service plan was not signed or dated by the resident and lacked documentation to suggest the resident received a copy of the service plan. 4. The clinical record of Resident J was reviewed on 12-4-23 at 11:28 a.m. His diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease). He has been a resident of the facility for over one year. A review of his most recent "Level of Service Assessment/Evaluation" was dated 9-29-23. His most recent service plan indicated an initial service plan was dated 6-17-22, with no further updates. In an interview on 12-4-23 at 1:07 p.m., with the Director of Nursing, he indicated he could not locate any other service plan for this resident. The most recent service plan was not signed or dated by the resident and lacked documentation to suggest the resident received a copy of the service plan. 5. The clinical record of Resident K was reviewed		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 Director of Nursing or Assisted Director of Nursing will monitor level of care assessments at admission, with change of condition, quarterly, and annually. They will also identify changes in resident status and an updated service plan as warranted. No service plan update is made if there is no change in level of care. Audits will continue by the Director of Nursing or Assisted Director of Nursing and be completed weekly for three (3) months after the initial month of daily audits. Corrections will be made at the time of discovery. They will review level of care assessments for accuracy and service plans that match. 5 By what date will the systematic changes be completed: a Compliance by: 4/1/24	

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	on 12-5-23 at 1:45 p.m. His diagnoses included, but were not limited to, Parkinson's Disease and diabetes. He has been a resident of the facility for over 5 months. A review of his most recent "Level of Service Assessment/Evaluation" was dated 9-12-23. The clinical record failed to include a service plan. In an interview with the Director of Nursing on 12-5-23 at 2:27 p.m., he indicated he was unable to locate a service plan for Resident K. On 12-5-23 at 1:52 p.m., the Executive Director provided a copy of a policy entitled, "Service Plans." This policy was indicted to be currently utilized by the facility and was listed to be most recently revised on 1-12-22. This policy indicated, "The purpose of this policy is to ensure that a plan of care is being developed by the Director of Nursing or designee for each resident within seven days of completion of assessment tool, following a significant change in condition or annually. Each resident will have a written plan of care that is developed based on initial assessment, annual comprehensive assessment, quarterly evaluations, and changes in resident needs. This plan will be available for staff review to assist in the daily care/services provided to the resident. The Director of Nursing, or designee, will complete the initial service plan within 24 hours of admission. The Director of Nursing, or designee, will complete the Service Plan within seven days of completion of the assessment tool...The Director of Nursing, or designee, will review the Service Plan every quarter and upon significant change in condition...The Director of Nursing, or designee, will review and update the service plan as dictated by changes in resident needs or preferences...All service plans are to be reviewed every quarter, upon significant change			

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	in condition and as dictated by changes in resident needs or preferences." 2.5-2(e)(1)(A) 2.5-2(e)(1)(B) 2.5-2(e)(1)(C) 2.5-2(e)(1)(D) 2.5-2(e)(2) 2.5-2(e)(3)			