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	07/27/2022

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 the Investigation of Complaints IN00386276 and IN00385830. Complaint IN00386276- Substantiated. State Residential Findings are cited at R52 and R217. Complaint IN00385830 - Substantiated. State Residential Findings are cited at R52 and R144. Survey Dates: July 25, 26, and 27, 2022 Facility Number: 013347 Residential: 113 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 29, 2022	R 0000		
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 observation, interview, and record review, the facility failed to respond to a resident's call light resulting in delayed hospitalization and treatment for acute exacerbation of chronic obstructive pulmonary disease (COPD) with shortness of breath for 1 of 4 residents reviewed for call light response and to ensure a resident	R 0052	R 052 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - R 052 Based on observation, interview, and record review, the facility failed to respond to a resident's call light resulting in delayed hospitalization and	08/19/2022

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

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	remained free from physical abuse for 1 of 3 residents reviewed for abuse. (Residents B and D) Findings include: 1. The clinical record for Resident B was reviewed on 7/25/22 at 3:14 p.m. The diagnoses included, but were not limited to, COPD. The 6/22/22 Level of Service Assessment/Evaluation indicated she was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She did not require assistance with medication procedures, but needed direct assistance with oxygen administration. The 3/23/22 comprehensive resident assessment instrument indicated in the last 30 days she received oxygen therapy and monitoring of an acute medial condition. The health condition section indicated she had shortness of breath and was unable to lie flat due to shortness of breath. The 3/23/22 self medication assessment indicated she could administer inhalant medications with proper procedure. The assessment results were that she was assessed and deemed to self medicate at an independent level. The active medications in the electronic health record included 2 puffs three times daily of Proair 90mcg inhaler; 2 puffs twice daily of Symbicort 160-4.5 mcg; 1 tablet of 10 mg singulair at bedtime; and 2 puffs once daily of 18 mcg Spiriva via hand inhaler. The 3/18/22 resident service plan indicated she		treatment for acute exacerbation of chronic obstructive pulmonary disease (COPD) with shortness of breath for 1 of 4 residents reviewed for call light response and to ensure a resident remained free from physical abuse for 1 of 3 residents reviewed for abuse. (Residents B and D) 1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice: The call light policy was reviewed and any long response times were noted and brought to nursing staff to educate them on timeliness. Both affected residents were separated by staff and monitored. No other residents have shown adverse effects. 2. How the facility will identify other residents having the potential to be affected by the same deficient practices and what corrective actions will be taken: Staffing shall be sufficient to ensure that all resident call lights are answered in an appropriate time per policy, and that residents are monitored to prevent altercations. 3. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur: The facility call light report will be monitored daily to ensure	

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	had a respiratory problem and needed oxygen due to her COPD. Her oxygen usage was 2L/min (minute) of continuous oxygen. The service to be provided was for her to report any problems with breathing or oxygen use and for nursing staff to monitor for signs/symptoms of oxygen deficit such as difficulty breathing. The objective was for her oxygen needs to be met and to be at reduced risk for complications. An observation and interview was conducted with Resident B on 7/25/22 at 3:14 p.m. in her room. She was wearing her oxygen via nasal cannula. Her bathroom was located to the left immediately upon entrance to her apartment. There was a call light with a pull cord on the wall next to the commode. She indicated on 7/10/22, she was wearing her oxygen and had done her breathing treatments, but couldn't breath. "I couldn't catch my breath." She was in her bathroom on the commode and pulled her call light. She waited and waited, but no one came. In the meantime, she remained still, because it hurt to even turn her head. No one was responding to her call light and she didn't bring her cell phone into the bathroom with her. Then she remembered she could get air from the tank on her motorized wheel chair, and the air would get to her "real fast." She then drove her wheel chair to get her cell phone from the other room and called 911, who placed her on hold. By this time, no one had yet answered her call light, which was still flashing. She was on hold with 911 so long, she hung up and called back. When they finally got on the phone, all she could say was help, [name of facility,] and [Resident B's room number.] She was unable to answer any of their questions. The EMTs (emergency medical technicians) came rather quickly. When they arrived, she was in her wheel chair, under the air vent in the kitchen. She		call lights are answered per policy. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Call light report audit will be completed weekly by DON and reviewed with Administrator.	

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	asked one of the EMTs to shut off her call light. They got her onto the stretcher, took her outside, and asked her where she wanted to go. She informed them she'd like to be taken to a specific hospital, but the EMTs informed her she needed to go to a different hospital that was closer, because she was "too near death" and that was the closest hospital. She begged them to take her to a different hospital, but they refused. She was at the hospital for 4 days due to a flare up of her COPD. Everyone saw her leave the facility and she spoke to the Administrator about it after returning to the facility. It was approximately 45 minutes from time she pressed her call light until the EMT came and shut it off. Nursing staff never did respond to her call light. The Alarm History Report was provided by the Administrator on 7/25/22 at 3:48 p.m. It indicated Resident B's bathroom call light was pulled on 7/10/22 at 6:24 p.m. It remained on and automatically timed out after 30 minutes at 6:54 p.m. The alarm remained on after the 30 minute time out for another 11 minutes and 45 seconds until the alarm was shut off at 7:06 p.m. The total elapsed time her call light was on was 41 minutes and 46 seconds. The 7/10/22 Ambulance Record indicated her call was placed and dispatch was notified at 6:51 p.m. They were en route at 6:54 p.m. They arrived on scene at 7:04 p.m. and departed the scene at 7:18 p.m. Resident B arrived at the hospital emergency department at 7:24 p.m. The narrative section read, "911 dispatch for difficulty breathing...On arrival found a [age and gender of Resident B] patient sitting up leaning forward on home 02 [oxygen] via NC [nasal cannula.] Able to speak short sentences. Onset times several hours. Multiple uses home neb [nebulizer.] Treatments without			

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	relief. BBS [Bilateral breath sounds] hard to hear any air movement. Duoneb started via mask. Preparing to star CPAP [continuous positive airway pressure.] Warm, dry, and pale. No JVD [jugular vein distention] or peripheral edema. Patient extremely anxious. Pulse ox [oximeter] 99-100 on 02....CPAP applied with neb attached. Patient wanted to go to [name of another hospital] but we were a mile and a half from [name of hospital to which Resident B went] ER [emergency room.] Emergent to [name of hospital emergency room.] IV attempted without success. ER contacted via Med4 and advised Patient is now breathing better and is more relaxed. BBS have opened up slightly. Report and signatures obtained." The 7/10/22 hospital notes indicated she was admitted to the emergency department on 7/10/22 at 7:33 p.m. for acute COPD exacerbation. They read, "presents with shortness of breath x [times] this morning. On initial examination, the patient was tachycardic [rapid heartbeat] and ill-appearing. She is in respiratory distress and speaking in short sentences on BiPAP. She was given solumedrol, NTG [nitroglycerin,] and duo-nebs in the ED for symptom control. WBC [White blood cells] resulted elevated at 15.2 CXR [chest x-ray] shows background emphysema. Troponin resulted unremarkable. POC [Point of care] lactate resulted elevated at 2.82. CT angio[Computed tomography angiography] shows no pulmonary embolism. Discussed the results of the ED findings with the patient and decision to admit to the hospital for further evaluation/treatment. The patient is agreeable to the plan of care." She was discharged from the hospital on 7/13/22. An interview was conducted with the QA (Quality			

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	Assurance) LPN (Licensed Practical Nurse) on 7/25/22 at 3:37 p.m. She indicated when a resident pulled their call light, the alarm went to the CNA's (Certified Nursing Assistant's) pager that they carried with them. The CNA either responded to the call light themselves or used their walkie talkie to communicate with other staff members regarding who would respond to the call light. On 7/26/22 at 12:12 p.m., the 7/10/22 daily nursing schedule was provided by the Scheduler, who is also a QMA (Qualified Medication Aide.) It indicated the Scheduler worked from 7:23 a.m. to 6:37 p.m. as a CNA (Certified Nursing Assistant.) CNA 3 worked 3:34 p.m. to 10:40 p.m. QMA (Qualified Medication Aide) 4 worked 7:26 a.m. to 11:00 p.m. QMA 5 worked 7:26 a.m. to 11:00 p.m. QMA 6 worked 12:46 p.m. to 6:36 p.m. QMA 7 worked 4:00 p.m. to 11:00 p.m. QMA 8 worked 3:30 p.m. to 6:30 p.m. An interview was conducted with the Scheduler on 7/26/22 at 12:12 p.m. She indicated she worked as a CNA on 7/10/22. She was in the laundry room folding clothes and getting ready to leave while Resident B's call light was alarming. She did not have a pager that day, and was pretty sure CNA 3 had the pager that day. She was unaware Resident B's call light was alarmed. CNA 3 was unavailable for interview. An interview was conducted with QMA 4 on 7/26/22 at 2:03 p.m. She indicated she was unaware Resident B's call light was alarming on 7/10/22 or that she went to the hospital that day. She did not carry a pager with her, as only the CNAs had pagers. An interview was conducted with QMA 5 on			

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	7/26/22 at 12:21 p.m. She indicated she was unaware Resident B's call light was alarming on 7/10/22. She was unaware Resident B went to the hospital on 7/10/22 until Resident B informed her of it when she returned to the facility. She was not carrying pager on 7/10/22, as only the CNAs carried pagers, from her understanding. An interview was conducted with QMA 6 on 7/26/22 at 2:06 p.m. She indicated she was unaware Resident B's call light was alarming on 7/10/22. She did not carry a pager with her, and none of the CNAs informed her that her call light was alarming. If she had known, she would have checked on her. She didn't find out about Resident B going to the hospital for "about a week." An interview was conducted with QMA 7 on 7/26/22 at 12:31 p.m. She indicated she was unfamiliar with who Resident B was. Call lights were alarmed through a pager system and "we've been telling them we need more pagers." No one informed her Resident B's call light was alarming or to go check on her. She did not have a pager that day, as CNAs are the ones who carry them and respond. QMA 8 was unavailable for interview. An interview was conducted with the DON (Director of Nursing) on 7/26/22 at 10:19 a.m. She indicated Resident B sent herself out to the hospital on 7/10/22 for shortness of breath. She was not present at the facility at the time. She reviewed Resident B's nurse's notes and 24 hour report and indicated there was nothing documented regarding her hospitalization on 7/10/22, because she transferred herself out and didn't notify nursing staff. She was aware			

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	Resident B pulled her call light. There was 1 to 3 pagers at all times. She stated, "I was aware there was a call light report and that she pressed the call light. I think we need to do some corrective action. I was informed it was a substantial amount of time." The Emergency Nurse call System policy was provided by the Administrator on 7/25/22 at 2:56 p.m. It read, "Procedure: A. When resident's emergency alert is activated, the following steps will be executed: 1. CNA or on call personnel will immediately go to the located alert. Alarm will be reset as soon as possible after emergency is identified. 2. Ask the resident the nature of the request. 3. Assist resident as needed. 4. Call for assistance, if needed. 5. Promptness is essential, the resident may be in an emergency situation such as chest pain, heart attack, difficulty breathing, have fallen, etc." 2. The clinical record for Resident E was reviewed on 7/26/22 at 10:54 a.m. The diagnoses included, but were not limited to, major depressive disorder. The 5/23/22 Level of Care assessment for Resident E indicated her behavior as, "Attitudes, disturbances and emotional states create daily difficulties, which are extremely difficult to modify to tolerable levels and can only be modified in a special setting and/or with a special plan." The 5/23/22 Comprehensive Resident Assessment indicated in the past 7 days she exhibited the following behavioral symptoms that were not easily altered, and had a history of in the last 6 months: verbally abusive behavioral symptoms (others were threatened, screamed at, or cursed at,) resists care (resident taking medications/injections, activities of daily living			

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	assistance, or eating,) intimidating behavior (made others feel unsafe or at risk; privacy invaded.) The clinical record for Resident D was reviewed on 7/26/22 at 10:59 a.m. The diagnoses included, but were not limited to, paranoid schizophrenia. The 7/19/22 incident report indicated, "When resident [initials of Resident D] approached a table resident [initials of Resident E] stabbed her [initials of Resident D] in the hand with her [initials of Resident E] fork....Assessment completed by nurse . Skin intact, no bruising or complaint of pain by [initials of Resident D....] Admin [Administrator] spoke with both residents, reminded of the rules/regulations/resident rights. Both residents expressed understanding. Both residents encouraged to reach out to staff for support during such situations." The 7/20/22 Resident Grievance Form, completed by the Administrator, read, "Investigation of Grievance: [Name of Resident E] was sitting at a table in the dining room eating when dietary staff refilled condiments, another resident approached the table that [name of Resident E] was sitting at and got condiments off the table. [Name of Resident E] used her fork and poked the residents [symbol for "left"] hand. Other resident identified as [name of Resident D.] Results: Admin [Administrator] spoke with each resident individually. Nursing staff assess [name of Resident D] at time of incident, skin intact, no signs of bruising. Admin discussed rules and common courtesy for other residents. Both [names of Residents E and D] expressed understanding. [Name of Resident E] was specifically asked why she touched [name of Resident D] with her fork and [name of Resident E's] response was]it's rude to reach across			

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	someone's plat.] [Name of Resident D] was asked if she was sitting at that table & she reported that she was getting her meal to-go that day. She approached the table that [name of Resident E] was sitting at to get condiments for her meal; as she was doing that [name of Resident E] took the fork she was using and poked [name of Resident D.] [Name of Resident D] reported that she pulled her hand back & moved away from the table, staff were present & separated the two residents. 7/20/22 Residents were monitored following incident, and no other disturbances occurred. Staff have been directed to continue to monitor. Incident reported to ISDH [Indiana State Department of Health.]" An interview was conducted with Resident D on 7/26 at 11:25 a.m. She indicated Resident E "She broke the law. It better not happen no more, and that's all I have to say." An interview was conducted with LPN (Licensed Practical Nurse) 9 on 7/27/22 at 12:44 p.m. She indicated saw the incident between Resident E and Resident D in the dining room. Resident D was sitting by the bureau upon entrance into the dining room. Resident E was sitting at the first table, where she sits everyday. Resident D wanted salt or sugar off of the table at which Resident E was sitting, so Resident D reached over the table to get it, but didn't contact Resident E during her reach. Resident E informed Resident D that she couldn't have anything from her table and jabbed Resident D in the arm one time. The fork was the same fork with which Resident E was eating. It made Resident D very upset and she told Resident E not do anything like that again. Resident E told Resident D to "shut up big mouth." LPN 9 assessed Resident D and cleaned the area. There was no broken skin. LPN 9			

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	indicated the incident was "unprovoked" and considered it physical abuse. An interview was conducted with DA (Dietary Aide) 10 on 7/27/22 at 1:17 p.m. He indicated he was present in the dining room during the incident. Resident D came to Resident D's table and asked for something, salt and pepper or something. Resident D leaned over the table to get it. Resident E then "gave her 2 pokes." Resident D started cursing at Resident E. Resident E called Resident D a "big mouth or crybaby or something." He asked Resident E why she poke her, but Resident E was nonchalant about it. The Abuse, Neglect, and Financial Exploitation Prevention policy was provided by the Administrator on 7/25/22 at 2:56 p.m. It read, "Residents of the community have the right to be free of abuse, neglect and financial exploitation." This Residential Tag relates to Complaints IN00386276 and IN00385830.			
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview, and record review, the facility failed to maintain the elevator in a cleanly fashion. This had the potential to affect 93 of 113 residents who lived on the 2nd, 3rd, and 4th floor of the facility. Findings include: An interview was conducted with Resident B on 7/25/22 at 3:14 p.m. in her apartment. She indicated	R 0144	R 144 410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview, and record review, the facility failed to maintain the elevator in a	08/19/2022

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	the main elevator floor was "so dirty." No one was mopping the floor everyday. "These floors are filthy." Her motorized wheel chair wheels were dirty from the hallways, as she did not take her wheel chair outside. An observation of Resident B's motorized wheel chair was made with Resident B on 7/25/22 at 3:14 p.m. in her apartment. Resident B's wheel chair was parked in her living room. The wheels were very dirty with debris. She moved the wheel chair back, so the floor underneath the wheels could be observed. The floors were blackened with debris. An observation of the main elevator was made on 7/25/22 at 3:40 p.m. and 7/26/22 at 11:19 a.m. There were spilled liquid spots and black debris particles on the floor. There was a significant amount of debris caked up in each of the 4 corners of the elevator. An interview was conducted with the Maintenance Director on 7/26/22 at 11:49 a.m. He indicated he was in charge of housekeeping at the facility. The housekeeping staff start cleaning the common areas, including the elevators, daily at 7:00 a.m. The cleaning of the elevator included mopping the floor. He stated, "The elevators are nasty. They're used more than bathrooms." An interview and observation of the hallway floors and elevator was made with the Maintenance Director on 7/26/22 at 11:53 a.m. He indicated the black debris on the floors was from motorized wheel chairs. It took a bit more than mopping to remove it from the floors. You needed to step on it and scrub a bit. The Maintenance Director indicated it didn't look like the corners of the elevator had been cleaned. All of the housekeepers were new, so they were still		cleanly fashion. This had the potential to affect 93 of 113 residents who lived on the 2nd, 3rd, and 4th floor of the facility. 1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice: The elevators were both cleaned. 2. How the facility will identify other residents having the potential to be affected by the same deficient practices and what corrective actions will be taken: Department Directors will walk the building daily and check elevators for cleanliness during those walks. Any elevator needing attention will be reported to the appropriate department director. 3. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur: Maintenance Director will add elevator cleaning on the housekeeping schedule. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Elevator audits will be completed weekly to ensure compliance and reviewed monthly in QA meeting.	

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		A. BUILDING 00 B. WING	07/27/2022

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	learning. He was short 1 of 4 housekeepers too. As far as a cleaning schedule, there was an old one that they no longer used, and staff did not document completion of cleaning tasks. The Maintenance Director provided a copy of the old cleaning schedule on 7/26/22 at 11:53 a.m. It indicated elevators were to be cleaned daily. This Residential Tag relates to Complaints IN00385830.			
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			

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	provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to revise a resident's service plan to address her behaviors for 1 of 3 residents reviewed for abuse. (Resident E) Findings include: The clinical record for Resident E was reviewed on 7/26/22 at 10:54 a.m. The diagnoses included, but were not limited to, major depressive disorder. The 5/23/22 Level of Care assessment for Resident E indicated her behaviors as, "Attitudes, disturbances and emotional states create daily difficulties, which are extremely difficult to modify to tolerable levels and can only be modified in a special setting and/or with a special plan." The 5/23/22 Comprehensive Resident Assessment indicated in the past 7 days she exhibited the following behavioral symptoms that were not easily altered, and had a history of in the last 6 months: verbally abusive behavioral symptoms (others were threatened, screamed at, or cursed at,) resists care (resident taking medications/injections, activities of daily living assistance, or eating,) intimidating behavior (made others feel unsafe or at risk; privacy invaded.) The 7/19/22 incident report indicated, "When resident [initials of Resident D] approached a table resident [initials of Resident E] stabbed her [initials of Resident D] in the hand with her [initials of Resident E] fork....Assessment completed by nurse . Skin intact, no bruising or	R 0217	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 involved in identification and documentation of the services to be provided.	08/19/2022

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	complaint of pain by [initials of Resident D....] Admin [Administrator] spoke with both residents, reminded of the rules/regulations/resident rights. Both residents expressed understanding. Both residents encouraged to reach out to staff for support during such situations." The 7/20/22 Resident Grievance Form, completed by the Administrator, read, "Investigation of Grievance: [Name of Resident E] was sitting at a table in the dining room eating when dietary staff refilled condiments, another resident approached the table that [name of Resident E] was sitting at and got condiments off the table. [Name of Resident E] used her fork and poked the residents [symbol for "left"] hand. Other resident identified as [name of Resident D.] Results: Admin [Administrator] spoke with each resident individually. Nursing staff assess [name of Resident D] at time of incident, skin intact, no signs of bruising. Admin discussed rules and common courtesy for other residents. Both [names of Residents E and D] expressed understanding. [Name of Resident E] was specifically asked why she touched [name of Resident D] with her fork and [name of Resident E's] response was]it's rude to reach across someone's plat.] [Name of Resident D] was asked if she was sitting at that table & she reported that she was getting her meal to-go that day. She approached the table that [name of Resident E] was sitting at to get condiments for her meal; as she was doing that [name of Resident E] took the fork she was using and poked [name of Resident D.] [Name of Resident D] reported that she pulled her hand back & moved away from the table, staff were present & separated the two residents. 7/20/22 Residents were monitored following incident, and no other disturbances occurred. Staff have been directed to continue to monitor.		Based on interview and record review, the facility failed to revise a resident's service plan to address her behaviors for 1 of 3 residents reviewed for abuse. (Resident E) 1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice: An audit of the assessments will be completed to identify more discrepancies with the RSPs. The RSP will be updated to reflect a behavior status. No adverse effects have been noted for other residents. 2. How the facility will identify other residents having the potential to be affected by the same deficient practices and what corrective actions will be taken: An audit will be conducted by DON or Designee to identify any other RSPs affected by this deficient practice. 3. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur: Nursing staff will be in serviced on assessment and RSP policy & procedure. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: DON or Designee	

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	Incident reported to ISDH [Indiana State Department of Health.]" An interview was conducted with Resident D on 7/26 at 11:25 a.m. She indicated Resident E "She broke the law. It better not happen no more, and that's all I have to say." An interview was conducted with LPN (Licensed Practical Nurse) 9 on 7/27/22 at 12:44 p.m. She indicated saw the incident between Resident E and Resident D in the dining room. Resident D was sitting by the bureau upon entrance into the dining room. Resident E was sitting at the first table, where she sits everyday. Resident D wanted salt or sugar off of the table at which Resident E was sitting, so Resident D reached over the table to get it, but didn't contact Resident E during her reach. Resident E informed Resident D that she couldn't have anything from her table and jabbed Resident D in the arm one time. The fork was the same fork with which Resident E was eating. It made Resident D very upset and she told Resident E not do anything like that again. Resident E told Resident D to "shut up big mouth." LPN 9 assessed Resident D and cleaned the area. There was no broken skin. LPN 9 indicated the incident was "unprovoked" and considered it physical abuse. Resident E was "not a nice person," and made a lot of "racial slurs." An interview was conducted with DA (Dietary Aide) 10 on 7/27/22 at 1:17 p.m. He indicated he was present in the dining room during the incident. Resident D came to Resident D's table and asked for something, salt and pepper or something. Resident D leaned over the table to get it. Resident E then "gave her 2 pokes." Resident D started cursing at Resident E. Resident E called Resident D a "big mouth or crybaby or		to audit RSPs weekly to ensure behaviors are being accurately documented. Results of audits will be reviewed at QA with any patterns identified with resolution.	

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	something." He asked Resident E why she poke her, but Resident E was nonchalant about it. He stated, "I don't think [name of Resident E] likes Black women." The 5/12/21 resident service plan did not address Resident E's behaviors. An interview was conducted with the DON (Director of Nursing) on 7/27/22 at 9:59 a.m. She indicated when Resident E had behaviors, they would redirect her. She reviewed Resident E's service plan and indicated there was nothing addressing her behaviors, but she would update it. This Residential Tag relates to Complaints IN00386276.			