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	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00389266, IN00389283, IN00387427, IN00389935, IN00392800, IN00393477, IN00395111, IN00392636, IN00395109 and IN00400585. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00389266 - Substantiated. State deficiencies related to the allegations are cited at R041. Complaint IN00389283 - Substantiated. State deficiencies related to the allegations are cited at R041. Complaint IN00387427- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00389935 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00392800 - Substantiated. State deficiencies related to the allegations are cited at R041, R240 and R354. Complaint IN00393477 - Substantiated. State deficiencies related to the allegations are cited at R041. Complaint IN00395111 - Substantiated. State deficiencies related to the allegations are cited at R041. Complaint IN00392636 - Substantiated. State deficiencies related to the allegations are cited at R041, R052, R091, R240 and R354.	R 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alberta Taybior	Administrator	03/02/2023

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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	Complaint IN00395109 - Substantiated. State deficiencies related to the allegations are cited at R041. Complaint IN00400585 - Substantiated. State deficiencies related to the allegations are cited at R041. Unrelated deficiency cited. Survey date: February 7, 8, 9, and 10, 2023 Facility number: 014279 Residential Census: 113 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 15, 2023			
R 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on observation, interview, and record review, the facility failed to address a resident's grievance regarding the removal of lint in the dryers for 3 of 3 dryers observed, and to timely address residents' dietary service complaints. This affected 47 of 113 residents in the facility.	R 0041	· **POC R041** · **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** Associates were educated on the	03/31/2023

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	(Resident K) Findings include: 1. During an interview with Resident the Council President on 2/8/23 at 10:10 a.m., she indicated residents has had concerns regarding the removal of the lint in the dryers. The clinical record for Resident K was reviewed on 2/9/23 at 10:00 a.m. The diagnoses included, but were not limited to: diabetes mellitus, anxiety and hypertension. A care screening assessment dated 2/1/23 indicated Resident K was alert and oriented with no memory problems. The resident's cognitive daily decision making was rated as modified independence which indicated "some difficultly in new situations only." Observations were made with Resident K of the facility dryers on the 3rd and 4th floor laundry rooms on 2/9/23 at 10:45 a.m. The resident was observed removing the lint trays from the dryers that were located on the 3rd and 4th floor. There was accumulated lint observed inside 1 dryer vent on the 3rd floor and 2 dryer vents on the 4th floor. The resident at that time indicated she felt the facility was not cleaning out the lint in the dryers. The residents are told to clean out the lint trays which was reasonable to ask, but the facility staff should be cleaning out the dryer vent as it also collects the lint residue. She had addressed the concern "repeatedly" by writing up grievances and verbally addressing it with management. She felt the lint left in the dryers were a fire hazard. The dryers were not routinely cleaned, and the lint was not removed. She had addressed the concern for over a year now and nothing has been done.		grievance policy and how to assist residents in voicing concerns. · **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.** All residents have the potential to be affected by the alleged deficient practice. The administrator or designee will review and address resident concerns per the facility's grievance policy/process. · **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** The administrator/designee will maintain a grievance log/binder that documents residents concerns and how they were addressed, · **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; and** The grievance log/binder will be reviewed/audited weekly for six (6) weeks, every other week for eight (8) weeks and as needed until all grievances are addressed per policy. · **By what date the systemic changes will be completed.** Education and monitoring	

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	An interview was conducted with Housekeeper 10 on 2/9/23 at 11:16 a.m. She indicated she cleans and disinfects the dryer drum, but does not remove the lint from the dryer. The residents are responsible for the removal of the lint after each use. An interview was conducted with the Administrator on 2/9/23 at 1:35 p.m. She indicated she did not have any grievances from Resident K concerning the lint removal from the dryers. An interview was conducted with the Maintenance Director on 2/9/23 at 2:19 p.m. He indicated the lint removal from the dryers are cleaned on a rotation schedule. He vacuums the lint from the dryer vents monthly. The residents are to clean the lint trays after each use. He does not recall Resident K speaking with him about the lint removal in the dryers. The 3rd and 4th floor dryers were cleaned out about a month ago. He does not keep any documentation or records regarding the cleaning maintenance of the vents in the dryers. 2. On 2/9/23 at 11:45 a.m., the Administrator provided the monthly May, 2022 to present Resident Committee Meeting Agenda/Minutes. They included minutes and attendance logs for the following meeting dates: 5/24/22, 7/19/22, 8/16/22, 12/20/22, and 1/20/22. September, 2022 had an attendance log dated 9/20/22, but no minutes. The Administrator did not provide any minutes or attendance logs for October, 2022 and November, 2022. An interview was conducted with the Administrator on 2/9/23 at 11:45 a.m. She indicated she was unable to locate minutes or attendance		implemented now. Education will be completed by March 31, 2023	

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	logs for October and November, 2022 and the minutes for September, 2022. The 5/24/22 minutes indicated the following dietary services concerns: burnt food, portion sizes, no bread, peanut butter and jelly in the refrigerator, meal delivery, different egg options at breakfast, and serving the same meals at lunch and dinner. New ideas were to serve residents in sections in the dining room. The attendance log indicated 25 residents were in attendance at this meeting. The 7/19/22 minutes indicated the following dietary concerns: running out of food, different food in carry out meals, not getting soda pop, no menus, no over easy eggs, not getting a complete carryout meal, no condiments, and mushy vegetables. The attendance log indicated 18 residents were in attendance at this meeting. The 8/16/22 minutes indicated the following dietary concerns: residents wanted to meet the dietician, soda needed daily, watered down drinks, drinking from coffee cups, running out of food, wanting over easy eggs, cold food, attitudes of servers, and dishes not clean. The attendance log indicated 17 residents were in attendance at this meeting. The 9/20/22 attendance log indicated there were 30 residents in attendance at this meeting. The 12/20/22 minutes, documented by the Administrator, indicated the following dietary concerns: servers needed training, serving different kinds of foods, and having home cooked meals. The attendance log indicated 8 residents were in attendance at this meeting.			

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	The 1/20/23 minutes, documented by the Administrator, indicated there was an explanation of the ENP (Enhanced Nutrition Plan) and there was improvement noted in dining services with the presence of management No specific dietary concerns were documented. The attendance log indicated 22 residents were in attendance at this meeting. An interview was conducted with the Resident Council President on 2/9/23 at 2:33 p.m. She indicated during a resident council meeting in January 2023, the residents had brought concerns up regarding food. The facility indicated the food served was restaurant style, but the residents do not receive menus to choose what their meal will be as someone would do if they were in a restaurant. During the meeting, food concerns were discussed, but no resolution or response on those concerns. The petition regarding the food that was turned in a few months ago; the council still has not heard anything about how it will be resolved. Currently the residents' still have food concerns. The Administrator did discuss about a food program called ENP. The facility offers this option to receive more food choices for an additional charge. If the resident does not elect to pay the additional charge they do not get those additional food choice options. The residents would get one choice meal, and the list of the always available food items if they were available. They are not always available. The lunch meal served yesterday (2/8/23) was meatloaf, au gratin potatoes, and green beans. The meatloaf was plain nothing in it to "enhance the taste like peppers and onions." The au gratin potatoes were under cooked, but the green beans were good. The quality of food served currently still was a concern. "The food is awful." After reviewing the January 2023 resident council/food meeting			

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	minutes, the Resident Council President indicated she had not recorded the discussions in that meeting. There were food concerns reported during that meeting that were not listed under the dietary services. The residents had not reported the dining services had improvement. A test tray of the 2/8/23 lunch meal was sampled on 2/8/23 at 12:34 p.m. It included meatloaf, cheesy potatoes, and green beans. The meatloaf was observed to be lacking in flavor. The cheesy potatoes tasted crisp and undercooked. The green beans were good. All of the food was warm and served at an appropriate temperature. An interview was conducted with the Administrator on 2/10/23 at 10:07 a.m. She indicated she has been with the facility since November 2022. During the council meeting, a male resident did bring up a concern with quality of food. She asked the male resident for an explanation of quality of food. The resident responded with "you know what I mean." A female resident had indicated she didn't like the taste. After reviewing the resident council minutes in January 2023, the Administrator indicated she filled out the resident council minutes form with the concerns and comments discussed in January 2023 meeting. She did not have the Resident Council President review and/or sign the meeting minutes. The Administrator indicated, "It's my fault. I filled out the resident council minutes." It would be a good idea for resident council to record the council meeting minutes or at least sign off on it to ensure we are on the same page what was discussed in those meetings. An interview was conducted with the Resident Council President on 2/8/23 at 10:10 a.m. She indicated food concerns/grievances are brought			

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	up at the resident and food council meetings all the time. A petition was also done a few months ago with all the grievances related to food, and the resident council has not heard anything from the facility on how they plan to address the food concerns. It continues to be a problem with no resolutions. "The food served here is horrible." The following are the residents' concerns with the food: quality of the food served, food temperatures served cold, not offering a variety, portion sizes are small, snacks and menus are not provided, the meal substitutes are not available, and overcooked vegetables. On 2/9/23 at 2:50 a.m., Resident Council President provided a copy of her 8/29/22 Resident Grievance Form, a letter to the facility outlining dietary concerns, and a signature page with 47 signatures on it. An interview was conducted with Resident D's Representative at 2/7/23 on 12:09 p.m. He indicated Resident D had concerns with food served cold in the facility. An interview was conducted with Resident H's Representative at 2/7/23 at 1:45 p.m. She indicated Resident H had concerns with food variety, quality, and the temperature of the food. It was not served hot. An interview was conducted with Resident B on 2/7/23 at 2:04 p.m. He indicated, "The food was horrible." He had the following concerns with the food served from the kitchen: quality of the food, portion sizes were small, menus are not provided, and snacks are not available. An interview was conducted with Resident C on 2/8/23 at 2:15 p.m. He indicated the french fries			

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	served the previous day were"ice cold." He was in the dining room yesterday, just before dinner, and there were still dirty dishes on tables from lunch. Cleaning the dining room floor was the"biggest joke here." They try to make the CNAs (Certified Nursing Assistants) responsible for cleaning the dining room after meals, but they're hired to work for residents, not dietary. Dietary tells him they cant make over easy eggs, because they can't cook them. They recently initiated the new ENP, that you could order an entree and a side. He was diabetic and they served too much potatoes, rice and bread. Things weren't going to "be right," until the kitchen had their own staff. An interview and observation was conducted with Resident Q in the dining room at one of the tables on 2/9/23 at 10:41 a.m. There were food particles and crumbs underneath the table. Resident Q indicated she was a vegetarian. The salads they served were just lettuce and a few strips of carrots and tomatoes. The fresh fruit was canned pineapple, not fresh. She couldn't really eat grilled cheese, because it made her constipated. She questioned why dietary couldn't just "take me a bowl out before they put the meat in the entrees." She'd had this problem since 2019 and they didn't try to accommodate her being vegetarian. An interview was conducted with the Resident R on 2/9/23 at 10:58 a.m. She indicated the food portions are small. She sits in the back of the dining room. She received her meal last night, and the portion size was so small she asked staff if she could have more. The staff had stated that she could not have another portion; the kitchen was out. She had to go upstairs and fix her something else to eat.			

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	Resident T's Level of Services Assessment, dated 11/21/22, indicated Resident T was oriented to person, place, and time and understood her basic needs that must be met. During an interview on 2/9/23 at 2:36 p.m., Resident T indicated that the nursing staff were not very nice when they were assisting in the dining room. A lot of the time the nursing staff were not even aware of what food they were serving and would get the orders of everyone in the dining room before they gave the orders to the kitchen to be served out. Resident U's Level of Services Assessment, dated 1/5/23, indicated Resident U was oriented to person, place, and time and understood her basic needs that must be met. During an interview on 2/9/23 at 2:45 p.m., Resident U indicated that she had reported the nursing staff being rude in the dining room during the last resident council meeting. She often had to drink her drinks out of coffee cups instead of glasses because there were not enough glasses to go around. The nursing staff would sometimes take everyone in the dining rooms orders and then turn the orders into the kitchen, which would make everyone in the dining room be there for quite a while before anyone got served. The people who sat at tables in the front were always the first served, and by the time the back of the dining room was served, the kitchen frequently ran out of something that was being served. She felt that the people who sat in front got the "good stuff" and the back of the dining room got "what was left". When the office staff assisted with the dining service it was better, but the office staff did not always help. An interview was conducted with the DM (Dietary Manager) on 2/10/23 at 10:21 a.m. he indicated Resident U had complained about the aides being rude in the dining room. She			

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	understood that the aides didn't like like serving, but they were rude to the residents at times. Resident U voiced this during the resident council meeting approximately 2 weeks ago. The DM indicated Some of the aides took all the tables orders at once prior to submitting the orders to the kitchen and other aides would go table to table. An interview and observation was conducted with the DM on 2/8/23 at 10:44 a.m. in the dining room at one of the tables. There was an Always Available menu posted at the table and each of the other tables in the dining room. The menu indicated the following 5 choices as a main meal: peanut butter and jelly sandwich, grilled chicken breast, cold salad sandwich (tuna, egg, or chicken salad,) deli sandwich of the day, grilled cheese. The 4 sides listed on the menu were cottage cheese, soup of the day, garden salad, and fresh fruit. The beverages listed were milk, coffee, iced or hot tea, juice, and lemonade. The bottom of the menu read, "These options are always available to residents in the event that the planned daily specials are not accepted or refused. We ask that requests for extras or second portions wait until the end of meal service or after all residents have been served." The DM indicated he'd been the DM for 9 months at the facility. Lunch service began at 11:00 a.m., starting with the drinks, then salads, then entrees. They took residents' orders when they came to the dining room, restaurant style. They always offered a substitute. Any resident not on the ENP always had the option of 5 choices listed on the Always Available menu at the table. The residents on the ENP have a substitute choice of another main entree. Today the main entree for lunch was meatloaf, cheesy potatoes, and green beans. The ENP substitute entree for lunch was smoked salmon, zucchini,			

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	and white rice. Servers were given a tablet to inform residents of what was being served for meals when they took their order. The residents on the ENP had a lanyard they wore to identify them, but some residents were reluctant to wear it, and the CNAs who served food hadn't been trained on he ENP program. He had residents calling him on the phone asking why one resident was given a choice and they weren't. There was no menu posted, but there was a chalkboard at the entrance to the dining room, which was residents' only notification of what was being served each day. They didn't have specific diabetic meals, mechanical soft meals, "or anything of that nature." Resident could always get fruit salad or baked chicken, and he tried to have items to accommodate. They regularly put out snacks, like meat sandwiches and peanut butter and jelly sandwiches, in the refrigerator at 2:00 p.m. daily and 7:00 p.m. daily when the dining room closed. The snacks were hard to manage, because some residents would take all of the snacks. Residents knew it was there and available, as that system was in place long before he began working at the facility. The Registered Dietician came twice a month to touch base about weight loss and provide the menu. They currently had 4 room trays for delivery, but used to have 18, until about 2 weeks ago. An interview was conducted with the Administrator on 2/9/23 at 2:00 p.m. She indicated residents stop her in the hallway with questions not concerns. The questions they ask are not normally put in writing. The questions are answered at that time or soon after. The questions are normally related to rent increases and ENP food program. She answers the residents' questions at that time.			

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	The Meal Service Policy and Procedure was provided by the Administrator on 2/7/23 at 12:29 p.m. It read, "It is the policy of the facility to provide our Residents with 3 well balanced and nutritious meals per day, as well as snacks. At lunch and dinner, residents will have a choice of at least 2 entrees at each meal....Beverages and snacks will be available in the dining room for residents on a 24-hour basis at no additional charge to the resident. The CNA Mealtime Duties was provided by the DM on 2/8/23 at 3:05 p.m. It read, " Take one tables orders at a time and take tickets to cook...You are responsible for your section and to make sure all empty tables are clean at the end of meal service." The Resident Grievance Policy and Procedure was provided by the Administrator on 2/7/23 at 11:25 a.m. It read, "All residents shall have the right to voice concerns and/or complaints which affect their lives at the facility without fear of discrimination or reprisal. Resident concerns and/or complaints should be presented to the appropriate management staff member. The appropriate department head will initiate the Resident Grievance Form. Once the Resident Grievance Form has been completed, it will be forwarded to the Administrator. The administrator shall oversee and ensure that a comprehensive investigation of the matter is conducted, corrective action is taken, if necessary, and a report is provided to the resident within 10 days of filing the complaint." This Residential Tag relates to Complaints IN00395109, IN00389283, IN00393477, IN00395111, IN00392636, IN00400585, IN00392800 and IN00389266.			

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		A. BUILDING 00 B. WING	02/10/2023

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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 ensure residents were free from physical and mental abuse for 2 of 4 residents reviewed for abuse. (Residents M, N and O) Findings include: On 2/7/23 at 11:56 a.m., the Administrator provided the 10/24/22 incident report into an altercation involving Residents M, N, and O that occurred on 10/23/22. It indicated Resident O argued with Resident M and Resident N that escalated to Resident O hitting at both Resident M and Resident N. Staff heard noise and came to intervene. There were no injuries. All residents involved were separated, questioned, and assessed by nursing staff. Residents were educated and advised to avoid engaging in arguments and instructed to alert staff for any potential future incident. The residents' families and physicians were contacted, and the DON (Director of Nursing) followed up with each resident. Follow up mental health services were offered to residents. A mental health clinician would come onsite to evaluate. An interview was conducted with the Administrator on 2/7/23 at 1:45 p.m. She indicated she was unable to locate the investigative file into the 10/23/22 altercation involving Residents M, N, and O.	R 0052	· **POC R052** · **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** Resident N no longer resides at the community. · **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.** All residents have the potential to be affected by the alleged deficient practice. Interviews with residents did not indicate any prior or further incidents. · **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** The DON/designee will refer any resident with maladaptive behaviors to psych services. · **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	03/31/2023

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	The clinical record for Resident O was reviewed on 2/7/23 at 2:04 p.m. The diagnoses included, but were not limited to, congestive heart failure. Resident O's 11/3/22 Indiana Resident Assessment Instrument indicated she exhibited verbally abuse behavioral symptoms, physically abusive behavioral symptoms, and intimidating behavior 1-5 days in the last 30 days. Resident O's 10/24/22, 11:28 a.m. nurse's note, written by the DON, read, "Res [Resident] was involved in a physical altercation yesterday 10/23, res stated that she was occupied to another female residents room with 2 other residents and approached resident at the door, at this time resident notice [sic] a male resident that she is involved with and approached male resident and slapped res, then turned around and approached female resident and punched and tried to bite resident but did not make contact. Res was tearful during conversation and states that she wants to continue to see male resident, but will not contact other female that she hit. Writer spoke with daughter and has sent a referral for mental health. Reporting ALTERCATION." Resident O's 10/24/22, 2:42 p.m. nurse's note, written by the DON, read, "f/u [follow up] mental health np [nurse practitioner] visited with resident, and met with writer shortly after, res did not speak on altercation with np, np stated that a male resident was currently keeping her company who she stated to be her boyfriend and she will visit at another time. writer f/u with resident and noted male resident who was involved in altercation with resident, res states that she is okay."		**assurance program will be put into place; and** Residents being seen by psych services will be monitored for behaviors weekly for six (6) weeks, every other week for eight (8) weeks and as needed until all residents continue to remain free of abuse. · **By what date the systemic changes will be completed.** Monitoring tools and reeducation are implemented now and will be completed by March 31, 2023	

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	Resident O's 10/26/22, 8:33 a.m. nurse's note, written by the DON, read, "writer followed up with resident, res continues to have no s/s [signs/symptoms] of psychosocial distress, res states that she is in love still with resident who she had hit d/t [due to] her being upset, she mentions they are working on their relationship and she is okay." The clinical record for Resident M was reviewed on 2/7/23 at 2:34 p.m. His diagnoses included, but were not limited to, chronic kidney disease and hepatitis C. Resident M's 1/13/23 Level of Service Assessment/Evaluation indicated he experienced difficulty in decision-making when faced with new tasks or situations. Resident M's 10/24/22, 10:58 a.m. nurse's note, written by the DON, read, "Res was involved in a physical altercation yesterday 10/23, res can not recall incident, so this writer asked certain questions for resident to answer, writer asked the following: Were you hit yesterday-res response yes and stated resident who did it. Where were you - res stated residents name of the apartment he was in. Why did this happen- res states he should not have been there. Are you scared of resident that hit you - no. Do you still want to see resident that hit you- yes. After further review resident is in a relationship with resident who had hit him. Skin assessment completed and no injury noted. Daughter notified and MD." Resident M's 10/24/22, 2:38 a.m. nurse's note, written by the DON, read, "f/u res continues to show no s/s of psychosocial distress, res continues to visit with female resident that hit him.			

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	Res states he is okay and is safe." Resident M's 10/26/22, 8:31 a.m. nurse's note, written by the DON, read, "f/u writer visited with res yesterday. he was with female resident that he had altercation with, res shows no s/s of psychosocial distress. writer visited briefly with resident this morning, res was leaving dining room to go the residents room with apple juice." An interview was conducted with Resident M in his room on 2/7/23 at 2:53 p.m. He indicated Resident O smacked him in the hallway right down the hall outside of Resident N's room. Resident O was his girlfriend at the time, and she was mad at him for visiting Resident N. The clinical record for Resident N, who no longer resided at the facility, was reviewed on 2/8/23 at 11:00 a.m. Her diagnoses included, but were not limited to, bipolar disorder, depressive disorder, and fibromyalgia. Resident N's 10/24/22, 10:40 a.m. nurse's note, written by the DON, read, " Writer was notified that res was involved in a physical/verbal altercation with other fellow residents yesterday evening 10/23/22. Writer f/u with resident this morning after coming off elevator from breakfast and res states that she came to her room and another resident (male) was already sitting in her apartment because she left her door unlock, res states she knew the resident and they were friends, she stated that she asked why resident in her room they stated to watch a movie, res agreed with doing so. Res then stated that someone knocked on her door and 3 female residents started calling her names and asking for a sweatshirt, then started yelling about the male resident she had in her room, she said that she			

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	tried to make residents leave, when one resident gabbed her then punched her in her left arm and tried to bite her forearm but did not make contact. Writer completed a skin assessment and no visible bruising/marks are noticed. Writer asked if she was [sic] felt safe. She stated yes but worried about going to meals, writer offered room trays and res denied, writer then offered res to have staff escort to meals. res stated that would be great. Writer asked res did she want male resident to return to her room at anytime she said no and that she told him not to come back. Writer has contacted MD, also sent referral for mental health f/u. Family contacted." Resident N's 10/26/22, 8:35 a.m. nurse's note, written by the DON, read, "Writer has followed up with resident yesterday and today, res is doing fine, she states she tries not to think about what happened, and is a little worried, mental health np visited with resident on Monday but res was not available at the time, np will revisit with resident next week." An interview was conducted with the DON on 2/7/23 at 3:09 p.m. She indicated she did not witness the altercation, but LPN (Licensed Practical Nurse) 2 did. LPN 2 informed her of the incident, so she followed up with each of the residents the next day. Resident Y was also present and "seemed to be the leader of the pack," as Resident Y informed Resident O that Resident M was in Resident N's room. Resident N informed the DON that she was hit by Resident O, but not bit. An interview was conducted with LPN 2 on 2/9/23 at 11:38 a.m. She indicated she'd worked at the facility for about a year. She was coming down the stairs and heard commotion coming from a room			

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	near the stairwell, so she went to the room. There were 2 female residents and one male resident in the room, but couldn't remember their names. The 2 females were arguing back and forth. The male resident was trying to get one of the female residents out of the room. One of the females didn't like that the male resident was visiting the other female. Both female residents were crying. "It was a mess." LPN 2 didn't observe anyone hit anyone else. Resident Y and another female resident were outside of the room in the hallway, talking about the situation, "saying she [Resident N] was a slut," and were shaming Resident N. The door was open and [Resident N] could probably hear them. LPN 2 checked on Resident N later. Resident N told her nothing like this had ever happened to her before, and was afraid to answer the door for the pizza she ordered. Resident N was "disgruntled, nervous acting," so LPN 2 reassured her and told her it would be okay. LPN 2 walked the floor 3 or 4 more times that shift and checked in on Resident N again. Resident N thanked her for checking on her. The Abuse, Neglect, and Financial Exploitation Prevention policy was provided by the Administrator on 2/7/23 at 11:25 a.m. It read, "Residents of the community have the right to be free of abuse, neglect and financial exploitation." This Residential Tag relates to Complaint IN00392636.			
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following:			

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	(1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to maintain documentation of an investigation into an incident of resident to resident abuse, per policy, for 3 of 4 residents reviewed for abuse. (Residents M, N, O, and Y) Findings include: On 2/7/23 at 11:56 a.m., the Administrator provided the 10/24/22 incident report into an altercation involving Residents M, N, and O that occurred on 10/23/22. The incident was reported by the previous Regional Operations Specialist. It indicated Resident O argued with Resident M and Resident N that escalated to Resident O hitting at both Resident M and Resident N. Staff heard noise and came to intervene. There were no injuries. All residents involved were separated, questioned, and assessed by nursing staff. Residents were educated and advised to avoid engaging in arguments and instructed to alert staff for any potential future incident. The residents' families and physicians were contacted, and the DON (Director of Nursing) followed up with each resident. Follow up mental health services were offered to residents. A mental health clinician would come onsite to evaluate. An interview was conducted with the Administrator on 2/7/23 at 1:45 p.m. She indicated she was unable to locate the investigative file into the 10/23/22 altercation involving Residents M, N, and O. She did not work at the facility at the time	R 0091	· **POC R091** · **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No resident was affected by the alleged deficient practice. · **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.** All residents have the potential to be affected by the alleged deficient practice. Conversations with residents did not indicate any prior or further incidents. · **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** The administrator/designee will maintain documentation of all investigations of resident abuse per policy. · **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; and**	03/31/2023

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	of the altercation and the investigation was conducted by the previous Regional Operations Specialist who no longer worked for the facility/company. The clinical record for Resident O was reviewed on 2/7/23 at 2:04 p.m. The diagnoses included, but were not limited to, congestive heart failure. Resident O's 11/3/22 Indiana Resident Assessment Instrument indicated she exhibited verbally abuse behavioral symptoms, physically abusive behavioral symptoms, and intimidating behavior 1-5 days in the last 30 days. Resident O's 10/24/22, 11:28 a.m. nurse's note, written by the DON, read, "Res [Resident] was involved in a physical altercation yesterday 10/23, res stated that she was occupied to another female residents room with 2 other residents and approached resident at the door, at this time resident notice [sic] a male resident that she is involved with and approached male resident and slapped res, then turned around and approached female resident and punched and tried to bite resident but did not make contact. Res was tearful during conversation and states that she wants to continue to see male resident, but will not contact other female that she hit. Writer spoke with daughter and has sent a referral for mental health. Reporting ALTERCATION." Resident O's 10/24/22, 2:42 p.m. nurse's note, written by the DON, read, "f/u [follow up] mental health np [nurse practitioner] visited with resident, and met with writer shortly after, res did not speak on altercation with np, np stated that a male resident was currently keeping her company who she stated to be her boyfriend and she will visit at another time. writer f/u with resident and		The administrator/designee will review/monitor all documented incidents of abuse in a designated log/binder weekly for six (6) weeks, every other week for eight (8) weeks and as needed. · **By what date the systemic changes will be completed.** Investigation documentation tool and resident conversations initiated and will be completed by March 31, 2023	

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	noted male resident who was involved in altercation with resident, res states that she is okay." Resident O's 10/26/22, 8:33 a.m. nurse's note, written by the DON, read, "writer followed up with resident, res continues to have no s/s [signs/symptoms] of psychosocial distress, res states that she is in love still with resident who she had hit d/t [due to] her being upset, she mentions they are working on their relationship and she is okay." The clinical record for Resident M was reviewed on 2/7/23 at 2:34 p.m. His diagnoses included, but were not limited to, chronic kidney disease and hepatitis C. Resident M's 1/13/23 Level of Service Assessment/Evaluation indicated he experienced difficulty in decision-making when faced with new tasks or situations. Resident M's 10/24/22, 10:58 a.m. nurse's note, written by the DON, read, "Res was involved in a physical altercation yesterday 10/23, res can not recall incident, so this writer asked certain questions for resident to answer, writer asked the following: Were you hit yesterday-res response yes and stated resident who did it. Where were you - res stated residents name of the apartment he was in. Why did this happen- res states he should not have been there. Are you scared of resident that hit you - no. Do you still want to see resident that hit you- yes. After further review resident is in a relationship with resident who had hit him. Skin assessment completed and no injury noted. Daughter notified and MD."			

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	Resident M's 10/24/22, 2:38 a.m. nurse's note, written by the DON, read, "f/u res continues to show no s/s of psychosocial distress, res continues to visit with female resident that hit him. Res states he is okay and is safe." Resident M's 10/26/22, 8:31 a.m. nurse's note, written by the DON, read, "f/u writer visited with res yesterday. he was with female resident that he had altercation with, res shows no s/s of psychosocial distress. writer visited briefly with resident this morning, res was leaving dining room to go the residents room with apple juice." An interview was conducted with Resident M in his room on 2/7/23 at 2:53 p.m. He indicated Resident O smacked him in the hallway right down the hall outside of Resident N's room. Resident O was his girlfriend at the time, and she was mad at him for visiting Resident N. The clinical record for Resident N, who no longer resided at the facility, was reviewed on 2/8/23 at 11:00 a.m. Her diagnoses included, but were not limited to, bipolar disorder, depressive disorder, and fibromyalgia. Resident N's 10/24/22, 10:40 a.m. nurse's note, written by the DON, read, "Writer was notified that res was involved in a physical/verbal altercation with other fellow residents yesterday evening 10/23/22. Writer f/u with resident this morning after coming off elevator from breakfast and res states that she came to her room and another resident (male) was already sitting in her apartment because she left her door unlock, res states she knew the resident and they were friends, she stated that she asked why resident in her room they stated to watch a movie, res agreed with doing so. Res then stated that someone			

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	knocked on her door and 3 female residents started calling her names and asking for a sweatshirt, then started yelling about the male resident she had in her room, she said that she tried to make residents leave, when one resident grabbed her then punched her in her left arm and tried to bite her forearm but did not make contact. Writer completed a skin assessment and no visible bruising/marks are noticed. Writer asked if she was [sic] felt safe. She stated yes but worried about going to meals, writer offered room trays and res denied, writer then offered res to have staff escort to meals. res stated that would be great. Writer asked res did she want male resident to return to her room at anytime she said no and that she told him not to come back. Writer has contacted MD, also sent referral for mental health f/u. Family contacted." Resident N's 10/26/22, 8:35 a.m. nurse's note, written by the DON, read, "Writer has followed up with resident yesterday and today, res is doing fine, she states she tries not to think abut what happened, and is a little worried, mental health np visited with resident on Monday but res was not available at the time, np will revisit with resident next week." An interview was conducted with the DON on 2/7/23 at 3:09 p.m. She indicated she did not witness the altercation, but LPN (Licensed Practical Nurse) 2 did. LPN 2 informed her of the incident, so she followed up with each of the residents the next day. Resident Y was also present and "seemed to be the leader of the pack," as Resident Y informed Resident O that Resident M was in Resident N's room. Resident N informed the DON that she was hit by Resident O, but not bit.			

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	An interview was conducted with LPN 2 on 2/9/23 at 11:38 a.m. She indicated she'd worked at the facility for about a year. She was coming down the stairs and heard commotion coming from a room near the stairwell, so she went to the room. There were 2 female residents and one male resident in the room, but couldn't remember their names. The 2 females were arguing back and forth. The male resident was trying to get one of the female residents out of the room. One of the females didn't like that the male resident was visiting the other female. Both female residents were crying. "It was a mess." LPN 2 didn't observe anyone hit anyone else. Resident Y and another unknown female resident were outside of the room in the hallway, talking about the situation, "saying she [Resident N] was a slut," and were shaming Resident N. The door was open and [Resident N] could probably hear them. LPN 2 checked on Resident N later. Resident N told her nothing like this had ever happened to her before, and was afraid to answer the door for the pizza she ordered. Resident N was "disgruntled, nervous acting," so LPN 2 reassured her and told her it would be okay. LPN 2 walked the floor 3 or 4 more times that shift and checked in on Resident N again. Resident N thanked her for checking on her. An interview was conducted with the Administrator on 2/8/23 at 10:26 a.m. She indicated she was still unable to locate the investigative file. The DON worked at the facility at the time, "so she could probably piece it together." She was unsure who the third female was referenced in Resident N's nurse's note. The Abuse, Neglect, and Financial Exploitation Prevention policy was provided by the Administrator on 2/7/23 at 11:25 a.m. It read,			

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		A. BUILDING 00 B. WING	02/10/2023

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	"Residents of the community have the right to be free of abuse, neglect and financial exploitation....Investigation: The Department Manager along with the Administrator will investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the Department Manager and the Administrator. Documentation of the investigation will be maintained by the Administrator." This Residential Tag relates to Complaint IN00392636.			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to complete a fall incident report per the facility policy for 1 of 3 residents reviewed for falls, and to administer ferrous sulfate (iron medication) as ordered, to report blood sugars less than 90 or greater than 250 and to timely obtain prescription eye drops as ordered for 3 of 4 residents medications reviewed. (Residents' F, G, R, and S) Findings include: 1. The clinical record for Resident G was reviewed on 2/9/23 at 10:00 a.m. The diagnoses included, but were not limited to: emphysema and Chronic Obstructive Pulmonary Disease. A nursing progress note dated 10/13/22 indicated "Resident stated she fell when she was going to the living room, no complain (sic) of pain or injury	R 0240	**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. DON or designee will provide an in-service to all QMAs and Nurses on properly completely incidents reports following a fall with or without injury. Employees found to be out of compliance with	03/31/2023

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	noted at this time..." The medical chart did not include a fall incident report. An interview was conducted with the Administrator on 2/9/23 at 3:30 p.m. She indicated she was unable to locate a fall incident report for Resident G. A fall policy was provided by the Administrator on 2/7/23 at 11:25 a.m. It indicated, "...All Community residents are included in the Community's Fall Prevention and Management Program which includes: assessment of the fall risk and initiation of both universal and individualized fall prevention interventions...C. Upon a resident fall event, an immediate assessment...and/or evaluation...of the resident will be completed to determine any possible injury. The licensed nurse at the Community shall be promptly notified and consulted as appropriate. Any injuries noted shall be communicated to the Community licensed nurse for consideration of further direction. Any post fall interventions determined shall be implemented and documented in the medical record...E. The resident's primary care provider shall be notified of any fall event..G. The resident's representative or primary emergency contact shall be notified of fall event...H. An incident report shall be completed..." 2. The clinical record for Resident R was reviewed on 2/9/23 at 9:00 a.m. The diagnoses included, but were not limited to: hypertensive and constipation. A physician order dated 12/28/22 indicated Resident R was to receive 324 milligrams of		properly completely incident reports will receive additional education and possible corrective action. b. DON or designee will provide an in-service to all QMAs and Nurses on properly recording medication administration in the EMAR and process and procedure for ordering medications. **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. DON or designee will do an audit of all falls that require incident reports to be completed. DON or designee will audit EMAR, specifically “unavailable medications” to ensure medications are being reordered in a timely manner. 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**	

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	ferrous sulfate at bedtime. The January 2023 Medication Administration Record (MAR) indicated the following days Resident R had not received her ferrous sulfate: 1/16/23, 1/21/23, 1/22/23, 1/26/23, 1/27/23 and 1/30/22 - documented as "unavailable" The February 2023 Medication Administration Record (MAR) indicated the following days Resident R had not received her ferrous sulfate: 2/1/23, 2/2/23, 2/4/23, 2/6/234, 2/7/23, 2/8/23 - documented as "unavailable" An interview was conducted with Resident R on 2/9/23 at 10:58 a.m. She indicated she had gone without her iron medication (ferrous sulfate) for 3 weeks. She indicated she had told the nursing staff she needed to have the iron medication reordered. She does not like for them to reorder her medication without her approval. She told the nursing staff to reorder, but it was not done. As days went on without her medication, she called the pharmacy herself to have her medication sent. It should be here tomorrow. Resident R does not feel she should have to figure out what was going on with her medication and have pharmacy sent herself. An interview was conducted with the Director of Nursing on 2/10/23 at 10:21 a.m. She indicated Resident R was being charged for her ferrous sulfate medication. The resident indicated she would get it on her own. The resident then changed her mind and asked if the facility could get the ferrous sulfate through the pharmacy for her.		**will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit incident reports for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all incidents reports, related to falls, with or without injury are being properly completed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results b. The Director of Nursing or designee will audit the EMAR for medications marked “unavailable” for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all medications are being reordered timely. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **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 March 31, 2023	

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	The medical record did not include documentation indicating the unavailable ferrous sulfate was being addressed by staff with the resident. 3. The clinical record for Resident F was reviewed on 2/8/23 at 11:30 a.m. The Resident's diagnosis included, but was not limited to, diabetes. A physician's order, dated 7/12/21, indicated Resident F was to receive accuchecks (blood sugar test) before meals and at bedtime. The physician was to be called for blood sugar readings less than 90 or greater than 250. A Resident Service Plan, last updated 12/13/22, indicated Resident F had agreed for the facility to coordinate all her healthcare needs. The objective was for the facility staff to assist with healthcare needs as they arise. The service was for the staff at the facility to coordinate with Resident F's doctors, family contact, and guardian. A Resident Service Plan, last updated 12/13/22, indicated that Resident F used a freestyle libre (blood sugar monitor) and declines services to be checked. The objective for her to be at reduced risk for signs or symptoms of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar) complications. The services included, but were not limited to, nursing staff to monitor accuchecks (blood sugars). An Assisted Living Facilities and Adult Care Home Assessment and Care Screening, completed 1/16/23, indicated Resident F had no problems with short- or long-term memory and able to recall the current season, location of her room, staff's names, and faces, and that she was in a facility. During an interview on 2/9/23 at 2:00 p.m., Resident F indicated that she did not always go			

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	down for meals in the dining room. Her blood sugar had been low in the morning several times. The January and February MAR (Medication Administration Records) indicated that Resident F's blood sugar had been below 90 or above 250 on the following days and times: 1/1/23 at 11:50 a.m. blood sugar reading of 87, 1/4/23 at 11:20 a.m. blood sugar reading of 83, 1/8/23 at 8:07 a.m. blood sugar reading of 85, 1/9/23 at 11:28 a.m. blood sugar reading of 82, 1/10/23 at 8:07 a.m. blood sugar reading of 85, 1/10/23 at 11:05 a.m. blood sugar reading of 74, 1/11/23 at 8:40 a.m. blood sugar reading of 87, 1/11/23 at 11:17 a.m. blood sugar reading of 81, 1/15/23 at 3:11 p.m. blood sugar reading of 75, 1/16/23 at 8:39 a.m. blood sugar reading of 74, 1/16/23 at 12:46 p.m. blood sugar reading of 263, 1/17/23 at 8:45 a.m. blood sugar reading of 73, 1/20/23 at 8:17 p.m. blood sugar reading of 282, 1/28/23 at 8:20 a.m. blood sugar reading of 83, 1/28/23 at 12:34 a.m. blood sugar reading of 81, 1/30/23 at 8:48 a.m. blood sugar reading of 60, and 1/31/23 at 9:49 a.m. blood sugar reading of 84. During an interview on 2/10/23 at 11:07 a.m., the DON (Director of Nursing) indicated that the notification of the physician about the abnormal blood sugars should be documented in the charting or nursing notes, and she did not see any notes about the physician being contacted. 4. The clinical record for Resident S was reviewed on 2/8/23 at 11:15 a.m. The Resident's diagnosis included, but was not limited to, glaucoma in both eyes and iridocyclitis (inflammation of the iris) in the left eye. A physician's order, dated 9/9/22, indicated			

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	Resident S was to receive Lumigan (glaucoma medication) 0.01% eye drops one drop into each eye at bedtime. A physicians' orders, dated 10/13/22, indicated Resident S was to receive Erythromycin (antibiotic) 0.5% ointment to the left eye three times daily and Prednisolone (for inflammation) 1% eye drops four times daily to her left eye and twice daily to her right eye. A Resident Service Plan, last updated on 12/21/22, indicated that Resident S needed assistance with ordering and setting up her medications and needed her medications administered to her. The objective included for her to have her medications regimen as ordered by the physician. The January and February 2023 MAR indicated that Resident S did not receive her Lumigan eye drops on January 5, 6, 7, 8, 10, 11 and 12, 2023 due to the drops being unavailable. She did not receive her Prednisolone eye drops on January 12, 13, 16, 17, and 20, 2023 due to the drops being unavailable. She did not receive her erythromycin eye ointment on January 20, 22, 24, 26, and 27, 2023 due to the ointment being unavailable. During an interview on 2/9/23 at 9:50 a.m., Resident S indicated that the facility did run out of her eye drops at times. The facility handled all her medications and was supposed to reorder her medications for her. During an interview on 2/10/23 at 11:07 a.m., the DON indicated that the facility did reorder mediations for Resident S. Her eye drops needed a new order in January 2023 the eye doctor had been notified by the facility and the pharmacy. She was when she had notified the eye doctor of			

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	the need for a new prescriptions. On 2/9/23 at 11:22 a.m., the Executive Director provided the Medication Management, Administration, and Storage policy, effective 3/2022, which read "...If a resident is assessed as Needing Assistance with Medication Administration, it is the responsibility of the licensed nurse or Qualified Medication Aide... to administer the medications to the resident...The provider will be notified by a licensed nurse...as indicated per any provider parameters noted within the medication orders..." This Residential Tag relates to Complaints IN00392800 and IN00392636.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure a resident's medical record was complete with documented blood sugar readings that were obtained prior to administration of insulin for 1 of 4 residents medications reviewed. (Resident F) Findings include: The clinical record for Resident F was reviewed on 2/8/23 at 12:00 p.m. The diagnoses included, but	R 0349	**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**	03/31/2023

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	were not limited to: type 2 diabetes mellitus and end stage renal disease. A physician order dated 10/13/22 indicated Resident F was to receive 3 units of humulin insulin in the evenings. The insulin should be held if blood sugar is less than 100. A physician order dated 11/9/22 indicated Resident F was to receive lyumjev insulin sliding scale at lunch time. The following sliding scale indicated the blood sugar readings and the insulin amounts to be given in the parameter of the blood sugar readings: 200 blood sugar - 300 blood sugars = 1 unit, 301 blood sugar - 400 blood sugar = 3 units A physician order dated 2/6/23 indicated Resident F was to receive 6 units of lymjeve insulin at lunch and 5 units of lyumjev insulin at lunch. The order indicated the staff was to hold if blood sugar was below 100. The February 2023 Medication Administration Record (MAR) for Resident F indicated the lyumjev sliding scale was utilized during lunch meals for the resident on the following days: 2/2/23 - documentation the staff administered 1 unit - no blood sugar reading recorded, 2/3/23 - documentation the staff administered 1 unit - no blood sugar reading recorded, 2/6/23 - documentation the staff administered 1 unit - no blood sugar reading recorded, The MAR indicated 7 units of lyumjev was administered on 2/6/23 to the resident at lunch. There was no blood sugar reading recorded. Resident F's clinical record did not include blood sugar readings during the lunch meals 2/2/23,		a. All residents with physician orders stating to document Blood Sugar readings, had the potential to be affected by the alleged deficient practice. DON or designee will audit all orders requesting documentation of Blood sugars. DON or designee will work with pharmacy to ensure all orders have blood sugar recording data entry requirement. **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:** b. DON or designee will do an audit of all orders requesting documentation of Blood sugars. DON or designee will work with pharmacy to ensure all orders have blood sugar recording data entry requirement. 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**	

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	2/3/23 and 2/6/23. An interview was conducted with the Director of Nursing (DON) on 2/8/23 at 3:27 p.m. She indicated she was unable to provide any additional blood sugar readings obtained and recorded for Resident F.		**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 blood sugar recordings for six (6) weeks, then every other week for eight (8) weeks, and then as needed to ensure that all blood sugars are properly reflected in the EMAR. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **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 March 31, 2023	
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. (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;			

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	(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 utilize a transfer form that included the name of the receiving facility, the property the resident had at the time of transfer, the functional and physical limitations of the resident, and the condition of the resident at the time of the transfer out of the facility for 1 of 3 residents reviewed for falls and 1 of 3 resident reviewed for change of condition. (Resident G and T) Findings include: 1. The clinical record for Resident G was reviewed on 2/9/23 at 1:00 p.m. The diagnoses included, but were not limited to: emphysema and Chronic Obstructive Pulmonary Disease. A nursing progress note dated 10/13/22 at 7:17 a.m., indicated "Resident stated she fell when she was going to the living room, no complain of pain or injury noted at this time..." A nursing progress note dated 10/13/22 at 8:00 a.m., indicated "Reporting Transition out on October 13, 2022 at 8:00 a.m., to Hospital/Admitted Reason(s): Fall..." The medical chart did not include a transfer form that included the following information that was provided to the receiving facility: name of receiving facility, the property the resident at the time of transfer, the functional and physical limitations of the resident, and the condition of the resident at the time of transfer.	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. DON or designee will do admission audit of all residents to ensure all proper documentation is listed on the residents facesheet (emergency printout) An In-service will be conducted with all nursing staff to ensure the proper use of transfer forms. **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. An audit of all new admissons will be conducted by the DON or designee. Any clinical staff member out of compliance	03/31/2023

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OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

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	An interview was conducted with the Director of Nursing on 2/10/23 at 10:21 a.m. The facility does not utilize a transfer form. The staff give the Emergency Medical Services (EMS) a copy of the emergency file which includes a list of the resident's medications and emergency contacts. We do not keep a copy of what was sent in the medical chart. 2. The clinical record of Resident T was reviewed on 2/9/23 at 2:35 p.m. The Resident's diagnosis included, but were not limited, hypertension and diabetes. A Level of Services Assessment, dated 11/21/22, indicated Resident T was oriented to person, place, and time and understood her basic needs that must be met. A progress note, dated 12/12/22, indicated Resident T had been sent the the acute care hospital due to a blood pressure of 177/99. The family and DON were notified. During an interview on 2/9/23 at 2:36 p.m., Resident T indicated that she had been sent to the hospital in December 2022. Her family member had called the emergency services to send her to the hospital and that the facility had not provided any information to the emergency services when she was sent out. There was no documentation present in the medical record about what information had been sent to emergency care hospital or given to the emergency services This Residential Tag relates to Complaints IN00392800 and IN00392636.		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 and the use of transfer forms 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 admission 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 facesheet. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **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	

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	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

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			March 31, 2023	