PRINTED: 05/03/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTII		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
			B. WING		03/23/2023	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIE	R		VASHINGTON AVE		
OASIS ASSISTED LIVING, INC				SVILLE, IN 47714		
0/10/071	COIOTED EIVIIVO,			, , , , , , , , , , , , , , , , , , ,		
(X4) ID	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG			TAG			DATE
R 0000						
Bldg. 00						
This visit was for the Investigation of Con		he Investigation of Complaint	R 0000	The Following Plan of Correct		
	IN00403865.			for Oasis Assisted Living rega	rding	
				the statement of deficiencies		
	_	3865: State deficiencies related		dated March 23, 2023. This pl		
	to the allegation(s)	are cited at: R052		correction is not to be constru		
		1 00 000		as an admission of or agreem		
	Survey dates: March 23, 2023			with the findings and conclusion		
	- "	10.510		in the statement of Deficiencie		
	Facility number: 01	13613		or any related sanction or fine	•	
	G D 1 T			Rather, it is submitted as		
	Census Bed Type:			confirmation of our efforts to		
	Residential 67			comply with statutory and		
	Total: 67			regulatory requirements. In thi	S	
				document, we have outlined		
	Census Payor Type: Medicaid: 31 Other: 36 Total: 67			specific actions in response to	1	
				identified issues. We remain		
				committed to the delivery of the		
				best quality health care servic		
	The State Desident	ial Findings are sited in		and will continue to make char and improvements to satisfy the	-	
The State Residential Findings are cited in accordance with 410 IAC 16.2-5.				iai		
	accordance with 410 fAC 10.2-3.			objective. The facility is also requesting desk review for		
Quality review completed on March 29, 2023.			compliance in these areas.			
	Quanty leview con	inpleted on Waren 27, 2023.		Compliance in these areas.		
R 0052	410 IAC 16.2-5-1	2(v)(1-6)				
	Residents' Rights					
Bldg. 00	_	re the right to be free from:				
g	(1) sexual abuse;	_				
	(2) physical abuse					
	(3) mental abuse;					
	(4) corporal punis					
	(5) neglect; and	•,				
	(6) involuntary se	clusion.				
		, observation and record	R 0052	The Following Plan of Correct	ion	04/14/2023
		failed to ensure residents were	100052	for Oasis Assisted Living rega		0 1/1 1/2023
	_	1 of 3 residents reviewed for		the statement of deficiencies	9	
		vas physically held down in a		dated March 23, 2023. This pl	an of	
				10, 2020 1110 p.	•	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Brandi Huffman Administrator 04/12/2023

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.

State Form Event ID: VEMF11 Facility ID: 013613 If continuation sheet Page 1 of 4

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/23/2023		
NAME OF PROVIDER OR SUPPLIER OASIS ASSISTED LIVING, INC			STREET ADDRESS, CITY, STATE, ZIP COD 4301 WASHINGTON AVE EVANSVILLE, IN 47714				
0/10/07/							
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	recliner by staff, and staff that reported				correction is not to be constru	ed	
	witnessing the abuse failed to intervene as they				as an admission of or agreem	ent	
	witnessed abuse.				with the findings and conclusions		
	Using the reasonable person concept, it is likely				in the statement of Deficiencies,		
	this would lead to chronic or recurrent fear and				or any related sanction or fine.		
	pain from the abuse.			Rather, it is submitted as			
	(Resident D)			confirmation of our ongoing efforts			
					to comply with statutory and		
	Finding includes:				regulatory requirements. In thi	S	
					document, we have outlined		
	_	v on 3/23/23 at 9:25 A.M., QMA			specific actions in response to)	
	7 indicated Resident D was not interviewable.				identified issues. We remain		
	During an observation on 3/23/23 at 9:30 A.M.,				committed to the delivery of the		
	Resident D was observed sitting in a common area				best quality health care services		
	with several residents during a group activity.				and will continue to make changes		
					and improvements to satisfy the	nat	
	During record review on 3/23/23 at 9:30 A.M.,				objective. The facility is also		
	Resident D's diagnoses included, but were not				requesting desk review for		
		ner's disease, vascular dementia,			compliance in these areas.		
	anxiety, history of stroke, and depression.				Tag # R053		
	l				What corrective action(s) will be		
	During a review of State reportable incidents on				accomplished for those reside		
	3/23/23 at 10:00 A.M., a reported incident included				found to have been affected by the		
	that Resident D was involved in a physical				deficient practice?		
	altercation with QMA 13 on 3/11/23 at 5:30 P.M.				To ensure the psycho-social		
					well-being and prevent future		
	A facility incident report dated 3/11/23 indicated				occurrence of inappropriate		
	Resident D was involved in a "staff on (Resident)				approach and deficient practic		
	abuse" incident. The report included that,				the QMA was terminated from the		
	Resident D had been exit seeking. Staff then				facility and reported to IDOH.		
	witnessed QMA 13 in the Resident D's room				Education was providing to all staff		
	holding both of the resident's hands down on her			of abuse policy, prevention, and			
	chair and standing over her in what appeared to				reporting process.		
	be a threatening manner. QMA 13 then left						
	Resident 13's room stating, "It's someone's else's				2 How will you identify ather		
	turn to babysit."				2. How will you identify other	•	
	An undated weitten	statement on the witnessed			residents having potential to b		
					affected by the same deficient		
	altercation between Resident D and QMA 13 on				practice?	ıl to	
	3/11/23 from Staff 4 included, "[QMA 13] went				All residents have the potentia	וו נט	

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STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
			B. WING			03/23/2023	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
0.4.010, 4.0010TED LIV/INIO, INIO					ASHINGTON AVE		
UASIS A	SSISTED LIVING,	INC		EVANS	SVILLE, IN 47714		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDED'S DI AN DE CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	to [Resident D's] ro	om with her (and) had her			be affected by the same defici	ent	
	sitting in her chair,	standing over her with her			practice systematic changes a	re	
	hand on [Resident I	O's] wrist/forearm (in a)			as follows:		
	_	ion. [Resident D] asked her to			All staff will be trained on Abus	se l	
	move. Then [QMA 13] came out (of the) room and				policy, prevention, and reporting		
		sic] turn to babysit. She on			upon hire and quarterly thereafter.		
		urday March 11, 2023 around			' ' '		
		[Resident D] stated her wrist					
	hurt"				3. What measures will be put i	nto	
					place or what systematic chan		
	A written statement	t, dated 3/11/23, on the			will make you to ensure	3	
		on between Resident D and			the deficient practice does not		
	QMA 13 on 3/11/23 from CNA 5 included, "I				recur?		
	witnessed [Resident D] exit seeking and				All Employees will be informed	, I	
	witnessed [Resident D] take [Resident D] to her			upon hire and trained at least			
	room and when I walked past she was forcing				quarterly thereafter of their		
	[Resident D] to stay in her recliner and would let				responsibility to intervene whe	n l	
	her get up. I stood there for about 5 minutes and				seeing deficient practices to	''	
	[QMA 13] didn't move and wouldn't move even				prevent harm to all residents a	nd	
	when [Resident D] asked her to move. This				to report immediately to their	ii iu	
		Iarch 11th 2023 around 5:30			supervisor, actual and/or		
	P.M 6:00 P.M."	iaren 11tii 2025 aroana 5.50			suspected incidents of resider		
	1 0.00 1				mistreatment, neglect, physica		
	Δn undated written	statement by QMA 13			sexual, verbal, or mental abus		
						e, oi	
	included, Resident [D] was walked to her room. I was asked to watch her till she calmed down.				misappropriation of resident property to the Administrator of	, l	
					1 1 1		
	Resident sat down on her recliner rocking				designee will be responsible for assuring that all	71	
	extremely hard. I asked resident to calm down				_	slv.	
	before she hurts herself and she got up and				alleged violations are thorough	ııy	
	aggressively started to com and hit me in the face			investigated, and the further			
	and I did grab her wrists for 2 seconds to prevent				potential abuse is prevented while		
	her from physically harming me and breaking my			an investigation is in process.			
	glasses."			4. How will the corrective action(s)			
	Duning a second of	al integritary Ctoff 4 :- 4:			be monitored to ensure the	ا ر	
	During a confidential interview, Staff 4 indicated				deficient practice will not recur		
	they witnessed QMA 13 holding Resident D's hands down after the resident had been						
		s. Resident D asked QMA 13			Administrator or designee will		
	repeatedly to let go and she kept holding her				complete an audit of all abuse		
	hands down, then QMA 13 walked out of the				reports to ensure Abuse repor	ting	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 03/23/2023		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD				
OASIS ASSISTED LIVING, INC			4301 WASHINGTON AVE EVANSVILLE, IN 47714				
(X4) ID	4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG			DATE	
		said it's someone else's turn		Checklist of required			
	-	t D complained that her wrists		documentation has been			
	_	ying the altercation. Staff 4		completed weekly for 30 days	and		
	_	ediately called the Facility		then monthly for 6 months.			
		to feeling they had just					
	Resident D.	being abusive towards					
	Resident D.						
	On 3/23/23 at 10:00	A.M., the Facility					
	Administrator supplied a facility policy titled,						
	Abuse Identification, Investigation, and						
	Reporting, dated 11	/16/18. The policy included,					
	"1. All facility em	nployees will be informed, up					
	hire and at least ann	nually thereafter, of their					
	responsibility to rep	port immediately to their					
	supervisor, or to fac	cility administration in the					
	_	pervisor, actual and/or					
	*	of resident mistreatment,					
		exual, verbal, or mental abuse					
		Health Services, or designee will					
		ssuring that all alleged					
		ughly investigated, and that					
	further potential about	use is prevented"					
	This Residential tag IN00403865.	g relates to Complaint					

State Form Event ID: VEMF11 Facility ID: 013613 If continuation sheet Page 4 of 4