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	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00403865. Complaint IN00403865: State deficiencies related to the allegation(s) are cited at: R052 Survey dates: March 23, 2023 Facility number: 013613 Census Bed Type: Residential 67 Total: 67 Census Payor Type: Medicaid: 31 Other: 36 Total: 67 The State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 29, 2023.	R 0000	The Following Plan of Correction for Oasis Assisted Living regarding the statement of deficiencies dated March 23, 2023. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to the delivery of the best quality health care services and will continue to make changes and improvements to satisfy that objective. The facility is also requesting desk review for compliance in these areas.	
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, observation and record review, the facility failed to ensure residents were free from abuse for 1 of 3 residents reviewed for abuse. A resident was physically held down in a	R 0052	The Following Plan of Correction for Oasis Assisted Living regarding the statement of deficiencies dated March 23, 2023. This plan of	04/14/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Huffman	Administrator	04/12/2023

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	recliner by staff, and staff that reported witnessing the abuse failed to intervene as they witnessed abuse. Using the reasonable person concept, it is likely this would lead to chronic or recurrent fear and pain from the abuse. (Resident D) Finding includes: During an interview on 3/23/23 at 9:25 A.M., QMA 7 indicated Resident D was not interviewable. During an observation on 3/23/23 at 9:30 A.M., Resident D was observed sitting in a common area with several residents during a group activity. During record review on 3/23/23 at 9:30 A.M., Resident D's diagnoses included, but were not limited to; Alzheimer's disease, vascular dementia, anxiety, history of stroke, and depression. During a review of State reportable incidents on 3/23/23 at 10:00 A.M., a reported incident included that Resident D was involved in a physical altercation with QMA 13 on 3/11/23 at 5:30 P.M. A facility incident report dated 3/11/23 indicated Resident D was involved in a "staff on (Resident) abuse" incident. The report included that, Resident D had been exit seeking. Staff then witnessed QMA 13 in the Resident D's room holding both of the resident's hands down on her chair and standing over her in what appeared to be a threatening manner. QMA 13 then left Resident 13's room stating, "It's someone's else's turn to babysit." An undated written statement on the witnessed altercation between Resident D and QMA 13 on 3/11/23 from Staff 4 included, "...[QMA 13] went		correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to the delivery of the best quality health care services and will continue to make changes and improvements to satisfy that objective. The facility is also requesting desk review for compliance in these areas. Tag # R053 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? To ensure the psycho-social well-being and prevent future occurrence of inappropriate approach and deficient practices the QMA was terminated from the facility and reported to IDOH. Education was providing to all staff of abuse policy, prevention, and reporting process. 2. How will you identify other residents having potential to be affected by the same deficient practice? All residents have the potential to	

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	to [Resident D's] room with her (and) had her sitting in her chair, standing over her with her hand on [Resident D's] wrist/forearm (in a) holding down position. [Resident D] asked her to move. Then [QMA 13] came out (of the) room and says someone else [sic] turn to babysit. She on my last nerve... Saturday March 11, 2023 around 5:30 P.M. - 6 P.M. [Resident D] stated her wrist hurt..." A written statement, dated 3/11/23, on the witnessed altercation between Resident D and QMA 13 on 3/11/23 from CNA 5 included, "I witnessed [Resident D] exit seeking and witnessed [QMA 13] take [Resident D] to her room and when I walked past she was forcing [Resident D] to stay in her recliner and would let her get up. I stood there for about 5 minutes and [QMA 13] didn't move and wouldn't move even when [Resident D] asked her to move. This happened on Sat, March 11th 2023 around 5:30 P.M. - 6:00 P.M." An undated written statement by QMA 13 included, Resident [D] was walked to her room. I was asked to watch her till she calmed down. Resident sat down on her recliner rocking extremely hard. I asked resident to calm down before she hurts herself and she got up and aggressively started to com and hit me in the face and I did grab her wrists for 2 seconds to prevent her from physically harming me and breaking my glasses." During a confidential interview, Staff 4 indicated they witnessed QMA 13 holding Resident D's hands down after the resident had been wondering the halls. Resident D asked QMA 13 repeatedly to let go and she kept holding her hands down, then QMA 13 walked out of the		be affected by the same deficient practice systematic changes are as follows: All staff will be trained on Abuse policy, prevention, and reporting upon hire and quarterly thereafter. 3. What measures will be put into place or what systematic changes will make you to ensure the deficient practice does not recur? All Employees will be informed upon hire and trained at least quarterly thereafter of their responsibility to intervene when seeing deficient practices to prevent harm to all residents and to report immediately to their supervisor, actual and/or suspected incidents of resident mistreatment, neglect, physical, sexual, verbal, or mental abuse, or misappropriation of resident property to the Administrator or designee will be responsible for assuring that all alleged violations are thoroughly investigated, and the further potential abuse is prevented while an investigation is in process. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Administrator or designee will complete an audit of all abuse reports to ensure Abuse reporting	

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	resident's room and said it's someone else's turn to babysit. Resident D complained that her wrists were hurting following the altercation. Staff 4 indicated they immediately called the Facility Administrator due to feeling they had just witnessed QMA 13 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 employees will be informed, up hire and at least annually thereafter, of their responsibility to report immediately to their supervisor, or to facility administration in the absence of their supervisor, actual and/or suspected incident of resident mistreatment, neglect, physical, sexual, verbal, or mental abuse... 4. The Director of Health Services, or designee will be responsible for assuring that all alleged violations are thoroughly investigated, and that further potential abuse is prevented..." This Residential tag relates to Complaint IN00403865.		Checklist of required documentation has been completed weekly for 30 days and then monthly for 6 months.	