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	09/04/2024

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 IN00441440, IN00441014, IN00440703, IN00438918, IN00437068, and IN00435224. Complaint IN00435224 - No deficiencies related to the allegations are cited. Complaint IN00437068 - State deficiencies related to the allegations are cited at R0216. Complaint IN00438918 - No deficiencies related to the allegations are cited. Complaint IN00440703 - State deficiencies related to the allegations are cited at R0241. Complaint IN00441014 - No deficiencies related to the allegations are cited. Complaint IN00441440 - No deficiencies related to the allegations are cited. Survey date: September 3 and 4, 2024 Facility number: 014279 Residential Census: 100 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 11, 2024.	R 0000		
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lily Price	Executive Director	09/26/2024

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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	Based on interview and record review, the facility to obtain semiannual weights for 2 of 3 residents reviewed for weight loss. (Resident D and C) Findings include: 1. The clinical record for Resident D was reviewed on 9/4/24 at 2:00 p.m. The diagnoses included, but were not limited to, gout and hypertension. The resident was admitted on 10/29/21. A vitals and weight report indicated Resident D's weight was last obtained on 12/11/23. 2. The clinical record for Resident C was reviewed on 9/4/24 at 10:21 a.m. The diagnoses included, but were not limited to, dementia, depressive disorder, and hypertension. Resident C was discharged from the facility on 7/2/24. The vital sign record for Resident C indicated the last record of his weight was completed on 10/19/23. No other weights had been recorded since 10/19/23. Resident C's service plan, dated 5/2/24, indicated nursing staff was to monitor the resident's vital signs and weight monthly and as needed. An interview was conducted with the Executive Director (ED) on 9/4/24 at 3:44 p.m. She indicated she was unable to locate any additional weights that were obtained for Resident D. The residents weights should be obtained monthly and documented in the clinical record. A "Health Promotion Policy and Procedure", undated, was provided by the ED on 9/4/24 at 4:01 p.m. It indicated "...Blood Pressure and weight checks will be offered to the residents once a	R 0216	Plan of Correction 09/26/2024 Facility ID: 014279 Survey Event ID: VHGZ11 R216 **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 requiring semi-annual weights, had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all CNAs, QMAs and Nurses on properly obtaining and documenting weights. Employees found to be out of compliance with properly obtaining residents weights will receive additional education and possible corrective action. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a All nursing staff educated on the policy no later than October	10/15/2024

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	month on a designated day. Blood pressure and weight will be taken by the Nursing Supervisor or designee and recorded in the resident chart..." This citation relates to Complaint IN00437068.		15, 2024. Any clinical staff member out of compliance with facility's policies and protocols relating to weights will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to obtaining weights 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 weights binder two (2) times per month for two (2) months, then one (1) time a month for twelve (12) months, and then as needed to ensure that weights are being properly obtained and recorded. 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 October 15, 2024.	

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R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on interview and record review, the facility failed to ensure the medications were administered in accordance with the physician's orders and failed to alert the physician when a resident, with a history of adrenocortical insufficiency, refused hormone replacement, blood pressure, supplement, immunosuppression, and steroid medications for 1 of 2 residents reviewed for death (Resident B). This deficient practice resulted in the resident experiencing an adrenal crisis, multi-system organ failure, and death. Findings include: The clinical record for Resident B was reviewed on 9/4/24 at 11:29 a.m. The diagnoses included, but were not limited to, adrenocortical insufficiency (a condition where adrenal glands don't make enough of the hormone cortisol, which helps to break down fats and proteins, and carbohydrates; controls blood pressure; and affects how the immune system works. Also known as Addison's disease), hypertension, hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone. A lack of thyroid hormone can disrupt the heart rate, body temperature, and all aspects of metabolism). Resident B's Saint Louis University Mental Status (SLUMS) evaluation (used to assess memory, language and attention), completed on 1/2/24, indicated he had a mild neurocognitive disorder. Resident B's vital signs record was reviewed on 9/4/24 at 11:29 a.m. The only vital signs recorded	R 0241	Plan of Correction 09/26/2024 Facility ID: 014279 Survey Event ID: VHGZ11 R241 **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 action will be taken;** a All residents that receive medications administered by the facility had the potential to be affected by the alleged deficient practice. DON and/or designee will ensure the residents physician and/or mental health provider are notified in a timely manner of residents refusal of medication. Employees found to be out of compliance with medication documentation will receive additional education and corrective action. **3 What measures will be put into place or what systemic changes the facility will make**	10/15/2024

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	for 2024 was completed on 1/5/24. Resident B's service plan, dated 2/23/24, indicated he needed medication assistance. The objectives included, but were not limited to, the licensed nurse to notify physician of any problems including noncompliance and adverse reactions and to follow medication regime as ordered per physician. It also indicated a need for assistance with washing his dishes, trash pickup, and laundering. A service plan for vital signs and weights indicated they should be recorded monthly for monitoring and assessment of significant changes. The objectives included, but were not limited to, his overall health will remain stable and managed. A review of Resident B's nursing notes, from 1/26/24 to 1/31/24, indicated he refused his medications on the following days and times: - On 1/26/24 at 9:22 a.m., resident requested his levothyroxine (medication for hypothyroidism) and "refused all his other morning medications." The nursing note did not indicate when/if his physician was notified of the medication refusal. No other nursing notes concerning his medications were posted until 1/30/24. - On 1/30/24 at 11:50 a.m., resident refused all his medications, and the nurse was notified. The nursing note did not indicate when/if the physician was notified of the medication refusals. No other nursing notes concerning his medications were posted until 1/31/24. - On 1/31/24 at 9:35 a.m., resident refused all his medications. The nursing note did not indicate when/if his physician was notified of the medication refusal. No other nursing notes concerning his medications were posted until 2/6/24.		**to ensure that the deficient practice does not recur;** a DON and/or designee will ensure the residents physician and/or mental health provider are notified in a timely manner of residents refusal of medication. Any clinical staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols 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 This process will be reviewed by ED/DON or designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved.	

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	Resident B's February 2024 medication administration report (MAR) indicated he had refused the following medications and the number of times he refused them: - amlodipine 2.5 mg (milligrams) (a blood pressure medication) was refused 10 times out of 29 possible administrations. - calcium antacid 500 mg was refused 20 times out of 58 possible administrations. - carvedilol 12.5 mg (a blood pressure medication) was refused 19 times out of 58 possible administrations. - cyclosporine 25 mg (an immunosuppressive medication) was refused 28 times out of 58 possible administrations. - levothyroxine 175 mcg (micrograms) (used to treat hypothyroidism) was refused on numerous administrations. - magnesium oxide 400 mg (a supplement) was refused 27 times out of 58 possible administrations. - prednisone 10 mg (used to treat adrenocortical insufficiency) was refused 10 times out of 29 possible administrations. A nursing note, dated 2/6/24 at 11:27 a.m., indicated resident refused all his medication, and the nurse was notified. The nursing note did not indicate when/if his physician was notified of the medication refusal. No other nursing notes were posted until the 3/4/24 note. Resident B's March 2024 MAR indicated he had refused the following medications and the number of times he refused them: - amlodipine 2.5 mg was refused three times out of four possible administrations.		**5 By what date the systemic changes will be completed;** a October 15, 2024	

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	- calcium antacid 500 mg was refused six times out of eight possible administrations. - carvedilol 12.5 mg was refused six times out of eight possible administrations. - cyclosporine 25 mg was refused five times out of eight possible administrations. - levothyroxine 175 mcg was refused four times out of four possible administrations. - magnesium oxide 400 mg was refused five times out of seven possible administrations. - prednisone 10 mg was refused three times out of four possible administrations. A nursing note, dated 3/4/24 at 9:37 p.m., indicated Resident B was sent to the local emergency room due to his "deteriorating condition" and was found lying naked in his bed, unable to walk, and was "barely" able to talk. A nursing note, dated 3/6/24 at 5:26 p.m., indicated Resident B passed away while at the hospital. The emergency department visit note for Resident B, dated 3/4/24 at 8:58 p.m., indicated he had a history of adrenal insufficiency, hypothyroidism, hypertension, and pancreatic insufficiency presented with hypotension (low blood pressure) and hypoglycemia (low blood sugar). "Per EMS [emergency medical service] report he has had poor PO [sic, by mouth] intake for 2 [two] weeks and either not taking medications or not taking them appropriately. EMS found glucose to be in 20s [sic, 20's]". Resident's blood pressure upon arrival to the emergency room was 85/52 and his temperature was 89.4 degrees Fahrenheit. Upon review of the laboratory tests completed, the most notable results were: - Magnesium was 0.86 mg/dL (milligrams per			

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	deciliter). A normal magnesium level is between 1.8 and 2.6 mg/dL. Magnesium helps muscles contract, nerves send signals, and the heartbeat regularly. Symptoms of magnesium deficiency include, but were not limited to, fatigue, muscle cramps, muscle weakness, and numbness. The article, "Magnesium", dated June 2, 2022, was retrieved, on 9/11/24, from the National Institutes of Health (NIH) website at https://ods.od.nih.gov/factsheets/magnesium-healthprofessional/. - Thyroid stimulating hormone (TSH) was 14.207 milliunits per liter (mU/L). A normal TSH level for an adult was 0.27 - 4.2 mU/L. High levels of TSH indicated an underactive thyroid gland. The thyroid hormones help control your weight, body temperature, muscle strength, and mood. The article "Thyroid Tests", dated May 2017, was retrieved, on 9/11/24, from the NIH website at https://www.niddk.nih.gov/health-information/diagnostic-tests/thyroid#:~:text=A%20high%20TSH%20level%20most%20often%20means%20you,keeps%20making%20and%20releasing%20TSH%20into%20your%20blood. - Lactate level was 7.5 (mmol/L) millimoles per liter. Normal lactate levels are less than 2 mmol/L. High levels of lactate are associated with increased risk of death independent of organ failure and shock. The article, "Etiology and therapeutic approach to elevated lactate", dated October 2013, was retrieved, on 9/11/24, from the NIH website at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3975915/. - Blood gas pH (measures the acidity or basicity of the blood) was 7.22. A normal blood pH is between 7.35-7.45. The blood pH result indicated acidosis which if untreated can lead to shock or			

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	death. The article, "Metabolic Acidosis", dated July 17, 2023, was retrieved, on 9/11/24, from the NIH website at https://www.ncbi.nlm.nih.gov/books/NBK482146/#:~:text=Metabolic%20acidosis%20is%20characterized%20by%20an%20increase%20in,to%20be%20corrected%20to%20minimize%20morbidity%20and%20mortality. - Ionized calcium (free calcium) was 3.55 milligrams per deciliter (mg/dL). A normal ionized calcium for adults was 4.8 to 5.6 mg/dL. Calcium builds strong bones and teeth and was important for heart function, muscle contraction, nerve signaling, and blood clotting. The article, "Calcium", dated July 24, 2024, was retrieved, on 9/11/24, from the NIH website at https://ods.od.nih.gov/factsheets/Calcium/HealthProfessional/#:~:text=The%20normal%20range%20of%20ionized%20calcium%20in%20healthy,4.6%20to%205.3%20mg%2FdL%20%281.15%20to%201.33%20mmol%2FL%29. The hospital assessment/plan, dated 3/4/24, indicated Resident B was to be admitted to the hospital with concerns for adrenal crisis and shock. He was intubated (a flexible tube inserted into trachea used to maintain an open airway) and required two vasopressors (a class of drugs that are used to treat low blood pressure) at admission. A critical care time note from Resident B's hospitalization, dated 3/5/24 at 7:30 a.m., indicated "[sic, resident's name] is an exceedingly critically ill patient who presented from an ecf [sic, extended care facility] after being found unresponsive with reported poor po [sic, by mouth] intake for the past 2 weeks...His evaluation has since revealed multiorgan failure as detailed below:			

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	1. Resp [sic, Respiratory] failure-acute, hypoxic [sic, lack of oxygen] and hypercapnic [sic, high carbon dioxide]. Decompensated around midday requiring intubation for uncompensated metabolic acidosis [sic, the buildup of bodily toxins] and unresponsiveness... 2. Shock- Suspect septic [sic, a life-threatening condition caused by a severe localized or system-wide infection] and hypovolemic [sic, form of shock caused by insufficient blood volume or fluid in the body] ...Lactate rising despite further IVF [sic, intravenous fluids] ...Cultures thus far show klebsiella [sic, a bacterium] in the blood... 3. Profound metabolic acidosis in setting of AKI [sic, acute kidney injury, condition where kidneys suddenly can't filter waste from the blood] ... 4. AKI [sic]- Suspect ATN [sic, acute tubular necrosis, a kidney disorder that damages the kidney's tubule cells, which help filter the blood] ... 5. Adrenal Crisis [sic, a life-threatening complication of adrenal insufficiency. Hypotension and hypovolemic shock are the main symptoms of adrenal crisis] ... 6. Myxedema coma [sic, an extreme form of hypothyroidism which is potentially lethal] - Known hx [sic, history] of hypothyroidism. Given constellation of findings including hypothermia, shock, encephalopathy [sic, a broad term for any brain disease that alters brain function or structure] ... 7. Pancytopenia [sic, a condition which there is significant reduction in the number of almost all blood cells] - Suspect septic... 8. Coagulopathy [sic, a condition in which the blood's ability to coagulate is impaired] ... 9. Transaminitis [sic, an elevated acetaminophen level] ... 10. Hypothermia...			

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	11. Hypoglycemia... 12. Acute encephalopathy..." A significant event note from Resident B's hospitalization, dated 3/6/24 at 5:10 a.m., indicated the resident's condition was worsening and there was a concern that he would not survive the next "24 hours." A hospital nurse practitioner's note, dated 3/6/24 at 8:46 a.m., indicated Resident B continued to decline overnight requiring four vasopressors, bicarbonate infusions, and continuous venovenous hemofiltration (a type of dialysis). Lactate levels continued to climb with continued pancytopenia and coagulation malfunctions. "Despite best efforts no improvement was seen. This morning family wishes were to transition to comfort measures." Resident B died at the hospital on 3/6/24 at 9:37 a.m. A copy of his death certificate, provided by his family on 9/5/24, indicated the cause of death was complications of adrenal crisis. An interview with Resident B's nurse practitioner 1 (NP 1) at the facility was conducted on 9/4/24 at 1:54 p.m. NP 1 indicated he had just taken over Resident B's care on February 14, 2024. He indicated prior to him becoming his patient, he had another provider but was last seen by that provider October 2023. He indicated he had seen Resident B, on 2/14/24 and 2/28/24, and did not have any concerns at that time. NP 1 indicated he had never been told by the facility that Resident B was refusing his medications. He indicated based on Resident B's medical history; he would want to be notified of such findings. He indicated if he had known about the refusals, he could have "highly educated" the resident on the importance			

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	of the medications he had prescribed to him, ordered laboratory tests, requested a psychological evaluation, or send the resident to the hospital. An interview with Resident B's family member was conducted on 9/3/24 at 11:20 a.m. They indicated when they got to the hospital, on 3/4/24, to see their dad, he was" howling" in pain, crying and begging for their help. She indicated no one from the facility notified the power of attorney that their dad's brother moved in to "take care of him" and a facility staff member had indicated to her that the staff didn't need to care of him because his brother was there to do that. They indicated when they went to the facility and looked at their dad's room there was mold on the dishes, his bed had feces on it, and all his plants were dead. They stated it was not like their dad to have his room messy. A change in condition policy, received on 9/4/24 at 4:02 p.m., indicated "All Community staff are responsible for promptly communicating any change in condition that is reported by a resident, loved one, and/or noted by any employee to the Director of Nursing or designee...D. Examples of change in condition may include, but is not limited to... 1. Significant, notable changes to intake pattern... 2. Decreased mobility/ range of motion, motor agitation or delay, weakness, decreased coordination... 3. Change in patterns of elimination... 4. Change in level of consciousness... 5. Decline in cognitive function, changes in communication/response... 7. Elevated or subnormal temperature... 11. Changes in vital signs... 12. Reaction/side effects to medications...			

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

(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
	13. Significant weight change... 14. Behavioral changes... 15. Falls...." A Daily Wellness Check policy was provided on 9/4/24 at 10:51 a.m. It indicated, "It is the policy of this community to perform a daily welfare check on each resident in order to provide a safe and reassuring environment for each resident...It is the responsibility of the C.N.A. [sic, certified nursing assistant] to check on each Resident, by visually laying eyes on them at least once daily..." A communication log printout was provided by ED (Executive Director) on 9/4/24 at 4:02 p.m. As it was explained by the ED, it indicated a wellness check was performed on Resident B on 3/4/24 at 9:00 p.m. The ED indicated it was at that time when they found the resident in his room unable to stand, walk, or talk. ED indicated the wellness checks only need to be completed once a day. This citation relates to Complaint IN00440703.			