STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS AT 30TH	5651 E 30TH STREET, INDIANAPOLIS, , 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00367617. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00367617: Substantiated. State residential findings related to the allegations are cited at R0036 and R0406. Survey dates: December 6 and 7, 2021. Facility number: 013347 Residential Census: 111 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 10, 2021	R 0000		
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2)	R 0036	R0036 – Residents’ Rights	12/07/2021

	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to inform residents and resident representatives of 3 new positive COVID-19 infections of staff with the potential to affect 111 of 111 residents residing at the facility. Findings include: During an interview on 12/6/21 at 4:30 p.m., the Administrator, Executive Director, and Director of Nursing indicated that the facility utilized an email system to notify residents and their representatives of new positive COVID-19 cases at the facility. They had not sent out an update for the facility for a while as the facility had not had any new positive cases. It was sent out when a new positive case of COVID-19 was identified. On 12/7/21 at 11:55 a.m., the		Corrective Actions for those residents found to have been affected: All residents have the potential to be affected. All department heads will notify Administrator immediately upon notification of a Covid positive staff member or resident. Administrator or designee will compose and distribute notification of Covid positive staff and/or resident on the CareMerge and posted in mail room of community within 24 hours. Other residents having the potential to be affected will be identified and actions taken: All Residents have the potential to be affected. All department heads will notify Administrator immediately upon notification of a Covid positive staff member or resident. Corrective measures put into place: Administrator or designee will compose and distribute notification of Covid positive staff and/or resident on the CareMerge and posted in mail room of community within 24 hours. How corrective action will be monitored: All department heads will report to administration daily with new Covid positive cases.	

	ED (Executive Director) provided a list of 3 staff members who have tested positive for COVID-19 in the past 4 months. The list included, CNA (Certified Nursing Assistant) H, who tested positive on 8/21/21, QMA (Qualified Medication Aide) F, who tested positive on 10/1/21, and CNA J, who tested positive on 11/17/21. During an interview on 12/7/21 at 2:20 p.m., the Executive Director indicated an email informing the residents and resident representatives had not been sent out within 24 hours of the 3 positive COVID-19 infections which had been identified. This Stage Tag relates to Complaint IN00367617. Based on interview and record review, the facility failed to inform residents and resident representatives of 3 new positive COVID-19 infections of staff with the potential to affect 111 of 111 residents residing at the facility. Findings include: During an interview on 12/6/21 at 4:30 p.m., the Administrator, Executive Director, and Director of Nursing indicated that the facility utilized an email system to notify residents and their representatives of new positive			

	COVID-19 cases at the facility. They had not sent out an update for the facility for a while as the facility had not had any new positive cases. It was sent out when a new positive case of COVID-19 was identified. On 12/7/21 at 11:55 a.m., the ED (Executive Director) provided a list of 3 staff members who have tested positive for COVID-19 in the past 4 months. The list included, CNA (Certified Nursing Assistant) H, who tested positive on 8/21/21, QMA (Qualified Medication Aide) F, who tested positive on 10/1/21, and CNA J, who tested positive on 11/17/21. During an interview on 12/7/21 at 2:20 p.m., the Executive Director indicated an email informing the residents and resident representatives had not been sent out within 24 hours of the 3 positive COVID-19 infections which had been identified. This Stage Tag relates to Complaint IN00367617.			
R 0406	Infection Control - Offense 410 IAC 16.2-5-12(a) (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable	R 0406	R0406 Infection Control Corrective Actions for those residents found to have been affected: All residents have the potential to be affected. All residents were	01/14/2022

environment and to help prevent the development and transmission of diseases and infection.

Based on observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 by not timely reporting 3 positive staff cases of COVID-19 to the Indiana Department of Health, not implementing outbreak testing after 2 staff tested positive for COVID- 19, not assuring unvaccinated staff were screened for signs and symptoms of COVID-19 prior to working, not monitoring unvaccinated residents for signs and symptoms of COVID-19, and not assuring staff utilized face shields when providing care within 6 feet of residents affecting 3 of 3 residents reviewed for COVID-19 monitoring, 3 of 3 staff reviewed for screening, 3 staff tested positive for COVID-19, and the potential to affect 111 of 111 residents residing at the facility (Residents B, C, and D, Certified Nursing Assistants E, H, J, and F, and Qualified Medication Aide G)

Findings include:

1. On 12/7/21 at 11:55 a.m., the ED (Executive Director) provided a list of 3 staff members who have tested positive for COVID-19 in the

screened for signs/symptoms of Covid. No resident was found to have signs/symptoms of Covid to warrant testing. Residents will be monitored ongoing for potential signs/symptoms of Covid and testing will be conducted as indicated per guidance.

Corrective measures put into place:

All residents will be notified of Covid positive cases within the community within 24 hours, this notification will be completed by Administrator or Designee within the appropriate timeframe.

Education will be provided to staff regarding Covid attestation forms policy & procedures in the form of an in-service. Audit of unvaccinated attestation forms will be conducted daily by Administrator or designee to ensure compliance with Covid attestation policy & procedure compared to the daily staffing schedule.

All staff will be educated about eye protection Covid policy & procedure. DON or designee to audit daily to ensure all staff follows eye protection policy & procedure. Eye protection guidance is posted in facility for staff review and reminder. In-service education provided to staff regarding eye protection use.

Outbreak testing will be conducted per guidance following positive results. Outbreak testing will continue every 3-5 days until no positive results return or per guidance provided by ISDH. All results of covid testing will be

	past 4 months. The list included, CNA (Certified Nursing Assistant) H, who tested positive on 8/21/21, QMA (Qualified Medication Aide) F, who tested positive on 10/1/21, and CNA J, who tested positive on 11/17/21. During an interview on 12/7/21 at 12:10 p.m., the DON (Director of Nursing) and the ED indicated that the 3 staff members had not been reported to the Indiana Department of Health when the positive test were received. Outbreak testing had not been started after receiving the positive test results. On 12/7/21 at 1:30 p.m., the Business Office Manager provided the timecard for the 3 positive staff members. CNA H's timecard indicated she had worked at the facility on 8/19/21 and was at the facility on 8/21/21 from 2:08 p.m. until 2:30 p.m. QMA F had worked at the facility on 9/30/21 from 8:25 a.m. until 1:39 p.m., and CNA F had last worked at the facility on 11/9/21. During an interview on 12/7/21 at 1:30 p.m., the DON indicated outbreak testing had not been initiated after CNA J's positive test because she had not worked at the facility in the 2 days prior to testing positive. She was unsure why outbreak		reported in Redcap. An audit of all resident's vaccination status was conducted to ensure all unvaccinated residents were identified and had the appropriate order entered into CareMerge to monitor for signs/symptoms of Covid and vital signs are entered into the electronic record daily. Ensure all unvaccinated residents have orders entered in Caremerge for temperature, O2 sats, and pulse to monitor for signs/symptoms of Covid daily. on-duty nurse will document that unvaccinated residents were screened for signs/symptoms of Covid daily via eMar. Any abnormal findings will be reported and monitored accordingly. DON or designee will audit daily to ensure vitals & Covid signs/symptom screens are being documented appropriately and residents are being tested and reported as necessary.	

testing had not been started for the other test results.

2. On 12/6/21 at 11:57 p.m., the Transportation Coordinator provided a list of staff members who were unvaccinated for COVID-19, which included CNA E, QMA F, and CNA G.

On 12/6/21 at 1:10 p.m., the DON Provided the scheduled as worked for 11/28/21 through 12/4/21, which indicated CNA E had worked on 11/28/21 on the night shift, 11/29/21 on the night shift, 11/30/21 on the night shift, 12/1/21 on the night shift, and 12/2/21 on the night shift. QMA F had worked 11/28/21 on the day shift, 12/1/21 on the day shift, 12/2/21 on the evening shift, and 12/3/21 on the day shift. CNA G had worked 11/28/21 on the day shift, 11/29/21 on the day shift, 12/2/21 on the day shift, 12/3/21 on the day shift, and 12/4/21 on the day shift.

During an interview on 12/6/21 at 3:10 p.m., CNA 5 indicated that staff were to screen for s/s of COVID-19 prior to starting their shifts. There were binders at the front desk which contained the screening forms that were to be filled out. One binder for vaccinated staff and one binder for unvaccinated staff.

During an interview on 12/7/21

at 1:45 p.m., the ED indicated that no unvaccinated employee screening forms could be found for CNA E, QMA F, or CNA G for the week of 11/28/21 through 12/4/21.

3. The clinical record for Resident B was reviewed on 12/6/21 at 1:40 p.m. The Resident's diagnosis included, but were not limited to, Hypertension. She was admitted to the facility on 11/29/21.

During an interview on 12/6/21 at 11:20 a.m., the DON (Director of Nursing) indicated she was receiving Transmission Based Precautions due to being recently admitted to the facility and unvaccinated.

Her clinical record did not contain daily monitoring for s/s (Signs or Symptoms) of COVID-19. There were no temperature readings recorded in the clinical record.

4. The clinical record for Resident C was reviewed on 12/6/21 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, diabetes and hypertension.

	On 12/6/21 at 2:15 p.m., the DON provided a list of vaccinated residents at the facility. She indicated that all others were unvaccinated for COVID-19. He was not included in the vaccinated list. The clinical record did not contain daily monitoring for s/s of COVID-19. There were no temperature readings recorded in the clinical record. 5. The clinical record for Resident D was reviewed on 12/6/21 at 3:20 p.m. The Resident's diagnosis included, but were not limited to, diabetes and hypothyroidism. He was not included on the list of vaccinated residents. The clinical record did not contain daily monitoring for s/s of COVID-19. There were no temperature readings recorded in the clinical record.			

During an interview on 12/6/21 at 2:20 p.m., the DON indicated the residents' temperatures and oxygen saturations were taken daily. If the staff noted signs of symptoms of COVID-19, they would let the nurse know so that it could be documented in the notes. There was a binder that the temperatures and oxygen saturations were recorded in for each resident daily. She was unsure of where the binder was but would locate it.

During an interview on 12/7/21 at 10:30 a.m., the DON indicated the binder containing the temperatures and oxygen saturations was not able to be located.

6. On 12/6/21 at 11:21 a.m., the Receptionist was observed sitting at the front desk. She was wearing a surgical mask and talking with a resident. She was not wearing a face shield or eye protection.

On 12/6/21 at 11:55 a.m., the dining room was observed. 3 staff members were serving lunch to the residents in the dining room. The 3 staff members were wearing surgical masks. They were not wearing face shield or eye protection.

On 12/6/21 at 3:56 p.m., Physical Therapist 4 was observed treating a resident in the upstairs common area. He

was assisting her to stand and walking beside her. He was wearing a surgical mask. He was not wearing a face shield or eye protection.

During an interview on 12/6/21 at 4:30 p.m., Physical Therapist 4 indicated he was not wearing a face shield or eye protection while treating the resident because it was not required by the facility. He wore eye protection if it was required by the facility when treating residents.

On 12/6/21 at 5:00 p.m., the county level of transmission rate was obtained from the CDC (Center for Disease Control) website. The county transmission rate was listed as high.

During an interview on 12/7/21 at 10:15 a.m., the Administrator indicated that she was unaware of the need for staff to wear eye protection, in high transmission counties, when providing care within 6 feet of a resident.

On 12/7/21 at 1:00 p.m., the ED provided the Indiana COVID-19 Notification policy, last approved 8/2021, which read "...Purpose: This policy offers directive and ensures compliance with...order requiring COVID-19 reporting for long-term care facilities and other congregated housing... Policy: All Indiana Residential

Care Facilities are required to report the following within 24 hours: Any resident who tests positive for COVID-19 Any employee who tests positive for COVID-19...The Administrator, or designee is responsible for reporting any resident or employee who tests positive for COVID-19..."

On 12/7/21 at 1:26 p.m., the ED provided the Universal Screening Policy, last approved 8/2021, which read "...In an effort to prevent and/or minimize the spread of any infection, residents, visitors and staff shall participate in universal screening for COVID-19 or COVID-19-like illness signs and /or symptoms. The administrator, or designee, is responsible for facilitating and monitoring compliance with universal screening measures...A. Residents: 1. All residents shall have a Daily Wellness Check Completed on a specified schedule. The director of nursing, or designee, shall review the Daily Wellness Check Form on a regular basis. The Administrator, or designee, is responsible for monitoring for appropriate completion and compliance...2. During the Daily Wellness Check, the following is monitored, including but not limited to; a. Temperature, pulse oximetry, pulse, and signs &[sic] symptoms of COVID-19 or COVID-19-like illness...B.

Employees: 1. All staff are expected to complete an Employee Attestation at the beginning of their shift. 2. The employee is responsible for completing the attestation in entirety. The administrator, or designee, is responsible for monitoring for appropriate completion and compliance...

On 12/7/21 at 9:30 a.m., the ED provided the COVID-19 Testing and Response Strategy policy, last approved 8/2021, which read "...Given the congregate nature of the Community and resident population served...senior living populations are at high risk of being affected by respiratory pathogens like COVID-19... 5. In response to an outbreak, or a single facility-onset COVID-19 infection in a resident, or a single new case of COVID-19 infection in a staff member, testing of all previously negative residents and staff, regardless of vaccination status occurs. Repeated retesting continues, generally every 3 to 7 days, until the testing identified no new cases of COVID-19 infection among residents or staff for a period of at least 14 days..."

The Indiana Department of Health COVID-19 Infection Control Guidance in Long-term Care Facilities, updated 11/22/21, was retrieved from the State of Indiana website on

12/6/21 at 5:10 p.m. which read "...HCP [sic] must wear face mask (medical) and eye protection, face shield /or goggles that cover top, bottom, sides of eyes with no gaps as a standard safety measure to protect LTC[sic]HCP[sic](SNF/AL)[sic] who provide essential direct care within 6 feet of the resident, regardless of COVID-19 status according to community transmission as follows...For substantial or high community transmission, then eye protection should be used by all HCP [sic] for all residents within 6 feet when delivering essential direct care regardless of COVID-19 status..."

This Stage Tag relates to Complaint IN00367617.

Based on observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 by not timely reporting 3 positive staff cases of COVID-19 to the Indiana Department of Health, not implementing outbreak testing after 2 staff tested positive for COVID- 19, not assuring unvaccinated staff were screened for signs and symptoms of COVID-19 prior to working, not monitoring unvaccinated residents for signs and symptoms of COVID-19, and not assuring staff utilized

face shields when providing care within 6 feet of residents affecting 3 of 3 residents reviewed for COVID-19 monitoring, 3 of 3 staff reviewed for screening, 3 staff tested positive for COVID-19, and the potential to affect 111 of 111 residents residing at the facility (Residents B, C, and D, Certified Nursing Assistants E, H, J, and F, and Qualified Medication Aide G)

Findings include:

1. On 12/7/21 at 11:55 a.m., the ED (Executive Director) provided a list of 3 staff members who have tested positive for COVID-19 in the past 4 months. The list included, CNA (Certified Nursing Assistant) H, who tested positive on 8/21/21, QMA (Qualified Medication Aide) F, who tested positive on 10/1/21, and CNA J, who tested positive on 11/17/21.

During an interview on 12/7/21 at 12:10 p.m., the DON (Director of Nursing) and the ED indicated that the 3 staff members had not been reported to the Indiana Department of Health when the positive test were received. Outbreak testing had not been started after receiving the positive test results.

On 12/7/21 at 1:30 p.m., the

Business Office Manager provided the timecard for the 3 positive staff members. CNA H's timecard indicated she had worked at the facility on 8/19/21 and was at the facility on 8/21/21 from 2:08 p.m. until 2:30 p.m. QMA F had worked at the facility on 9/30/21 from 8:25 a.m. until 1:39 p.m., and CNA F had last worked at the facility on 11/9/21.

During an interview on 12/7/21 at 1:30 p.m., the DON indicated outbreak testing had not been initiated after CNA J's positive test because she had not worked at the facility in the 2 days prior to testing positive. She was unsure why outbreak testing had not been started for the other test results.

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shift, and 12/3/21 on the day shift. CNA G had worked 11/28/21 on the day shift, 11/29/21 on the day shift, 12/2/21 on the day shift, 12/3/21 on the day shift, and 12/4/21 on the day shift.

During an interview on 12/6/21 at 3:10 p.m., CNA 5 indicated that staff were to screen for s/s of COVID-19 prior to starting their shifts. There were binders at the front desk which contained the screening forms that were to be filled out. One binder for vaccinated staff and one binder for unvaccinated staff.

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3. The clinical record for Resident B was reviewed on 12/6/21 at 1:40 p.m. The Resident's diagnosis included, but were not limited to, Hypertension. She was admitted to the facility on 11/29/21.

During an interview on 12/6/21 at 11:20 a.m., the DON (Director of Nursing) indicated she was receiving Transmission Based Precautions due to being recently admitted to the facility and unvaccinated.

Her clinical record did not contain daily monitoring for s/s (Signs or Symptoms) of COVID-19. There were no temperature readings recorded in the clinical record.

4. The clinical record for Resident C was reviewed on 12/6/21 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, diabetes and hypertension.

On 12/6/21 at 2:15 p.m., the DON provided a list of vaccinated residents at the facility. She indicated that all others were unvaccinated for COVID-19. He was not included in the vaccinated list.

The clinical record did not contain daily monitoring for s/s of COVID-19. There were no temperature readings recorded in the clinical record.

5. The clinical record for Resident D was reviewed on 12/6/21 at 3:20 p.m. The Resident's diagnosis included, but were not limited to, diabetes and hypothyroidism.

He was not included on the list of vaccinated residents.

The clinical record did not contain daily monitoring for s/s of COVID-19. There were no temperature readings recorded in the clinical record.

During an interview on 12/6/21 at 2:20 p.m., the DON indicated the residents' temperatures and oxygen saturations were taken daily. If the staff noted signs of symptoms of COVID-19, they would let the nurse know so that it could be documented in the notes. There was a binder that the temperatures and oxygen saturations were recorded in for each resident daily. She was unsure of where the binder was but would locate it.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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