Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002067	A. BUILDING: _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUSTIN OASIS, THE	901 SOUTH AUSTIN BLVD CHICAGO, IL 60644

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
S 000	Initial Comments Complaint Survey: 2480202/IL168527	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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S9999	Continued From page 1 care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure that adequate supervision was provided for five of five residents (R15, R16, R17, R18, and R19) reviewed for supervision in the sample. This failure affected R15 who had a fall with injury laceration to the right side of the head and was sent to hospital emergency room where R15 received seven staples for laceration closure. This also affected R16 who was noted in the shower room without any supervision and R17, R18 and R19 who were observed in the dining room during lunch time without supervision. This has potential to affect all the resident on the 2nd and 4th floor of the facility. Findings include: On 02/15/24 at 10:05am, R15 was observed in	S9999		

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bed with 7 (Seven) staples noted on the right side of the head. When the surveyor asked R15 what happen to R15's head. R15 stated that I (R15) fell in the shower, and I went to the hospital. R15 stated I was in pain, and it hurts bad. R15 stated on a scale of one to ten the pain was at 10. R15 stated they give me (R15) something for pain. R15 stated it still hurts now. R15 stated that there was no one (Referring to staff) to help me, R15 stated I was shouting for help, but no one came.

R15's medical record Admission Record showed that R15 was admitted to the facility on 05/01/23 with listed diagnosis that includes Schizophrenia, Unspecified, Acute Kidney Failure, Adjustment disorder with mixed anxiety and depressed mood, Bradycardia, and Vitamin D deficiency. On 02/09/24 had unwitnessed fall and was sent to the medical center.

R15's MDS (Minimum Data Set) facility assessment tool used in assessing facility resident showed R15 a score of 09 indicating that R15 is moderately cognitively impaired.

According to facility investigation report, V24 CNA (Certified Nurse's Aide) statement dated 02/09/24 documented that I (V24) took (R15) in the shower room and told him to wait until I come back. I told the other CNA identified by V2 DON (Director of Nurses) as V26 that R15 was in the shower room. V24 stated that when she came back R15 told her that R15 had a fall.

On 02/15/24 at 10:15am, V7 (MDS / Care plan coordinator) who identified self as the 4th floor supervisor stated that there are call light in the rooms and she will have to refer to V1 (Administrator) to share whether the shower room call light should be functional (In working

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condition). V5 LPN (Licensed Practical Nurse) stated that call light should be always placed within resident reach when in the room. V7 also stated that a staff member should be present when resident is in the shower room to monitor and supervise for safety reasons.

On 02/15/24 at 1:00pm, R17, R18 and R19 were observed in on the 2nd floor dining room eating with no staff supervision. R18 was observed trying to move the food plate so R18 can reach it. When this observation was brought to V18 CNA's attention and was asked about the facility protocol /policy on dining supervision. V18 who came into the dining area stated there should be a CNA assigned to monitor the dining room. V18 stated that R17 and R18 looking on their tray are on puree diet and should be monitored because they (referring to R17 and R18) can shock, they have problem in swallowing.

At 1:12pm, V27 RN (Registered Nurse) stated that the dining room should be monitored by the staff they are not supposed to be left by them self while eating, R17 and R18 are on puree diet and should be monitored by the (CNAs) because they are at high risk for aspiration.

At 1:41pm, V2 DON (Director of Nurses) stated whenever the resident is still eating in the dining room they should be monitored by staff and any staff can monitored. When asked specifically about monitoring or supervising for resident on mechanical diet puree diet. V2 stated the nursing staff should monitor.

R17's medical record admission record listed diagnosis includes but not limited to Anemia unspecified, Dysphagia, oropharyngeal phase, abnormal posture, weakness, and Extrapyramidal

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S9999	Continued From page 4 movement disorder. R18's medical record admission record listed diagnosis that includes but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, moderate protein-calorie malnutrition, chronic obstruction pulmonary disease unspecified, Type 2 diabetes mellitus without complications, acute respiratory failure with hypoxia, dysphagia following cerebral infarction, gastrostomy status and bell's palsy. R19 medical record admission record listed diagnosis that includes but not limited to Epilepsy, abnormal reflex, obesity, major depressive disorder, schizophrenia, hypothyroidism, unspecified psychosis not due to substance or known physiological condition and other intervertebral disc displacement lumbar region. On 02/15/24 at 10:10am, V8 (Housekeeping) staff who was cleaning the opposite room to the shower room was asked to observe with the surveyor the functionality of the call light system in the shower room. R16 was noted in the shower room without any staff monitoring or supervising the shower area or the room. V8 stated the CNAs are the staff who monitors during shower. At 10:14am, V22 (CNA) who identified self as CNA who was supposed to monitor the residents during shower was made aware of the observation and was asked about the facility policy on supervision during shower stated that the residents are to be monitored closely so the no one (referring to staff or other resident) can go in the shower room for safety of the resident because we don't know what can happen (referring to fall incident or abuse). V22 stated in	S9999		

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part that she is the only one on the floor and was checking on other resident's needs.

R15's fall care plan focus initiated 05/02/23 with revision date of 05/11/2023 documented that R15 is at risk for fall / accidents related to medical complexities, psychotropic medications. Goal indicated that (R15) will not sustain serious injury throughout the review date. Interventions listed includes but not limited to be sure that the resident (R15) call light is within reach.

R15's actual fall plan of care with revision date 02/08/24, listed interventions include resident (R15) instructed to use call light when feeling dizzy. Added intervention dated 02/09/24 documented that R15 instructed on importance of not trying to shower without assistance.

On 02/20/24 at 12:25pm, V26 confirmed that V24 made her aware that R15 was in the shower room but was sitting in the middle of the hallway documenting and was not aware that R15 fell. V26 stated she did not hear any sound to indicate that R15 had a fall until few minutes later when V24 called her to inform her that R15 fell and was bleeding. When asked about the facility protocol on monitoring or supervision when in the shower room. V26 stated that she was busy doing her own work documenting. Showing that R15 was not monitored or supervised before V24 returned to the shower room. V26 stated R15 was noted bleeding from the side of the head.

On 02/20/24 at 1:45pm, V25 NP (Nurse Practitioner) stated in part that she was paged to the 4th floor after the incident, and she examined R15. V25 stated R15 had approximately three (3) inches of laceration to the right side of the head and because R15 stated that (R15) hit the head

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S9999	Continued From page 6 on the floor and there was a laceration she ordered for R15 to be sent to the hospital for further examination because there is a possibility of other things going on. V25 stated that there was no loss of consciousness reported to her. V25 stated that on 02/11/24 at around 1pm she examined R15 upon return to the facility and there was 7staples applied for closure of the laceration. V25 stated the site is being monitored for swelling, redness and there is no special treatment dressing. V25 stated the staples will be removed in 7 to 14 days. The facility policy on Supervision and Safety dated 3/15 documented in part that the policy strives to make environment as free from hazards as possible, resident safety and supervision are facility-wide priorities. Resident supervision is a core component to resident safety. Staff to decrease safety risk factors as much as possible. The facility Job Description for Maintenance director presented documented in part that the maintenance director is responsible for the day-to-day activities maintenance department in accordance with current Federal, stated, and local standards guidelines and regulations governing the facility and maintained a clean, safe, and comfortable manner. Essential duties listed includes but not limited to maintains the building in good repair, maintain the building and grounds in compliance with federal, state, local, and joint commissions laws and standards. The facility LPN (Licensed Practical Nurses) Job Description presented documented in part that the primary purpose of the job is to provide direct nursing care to the residents and to supervise the day-to-day nursing activities performed by the nursing assistants in accordance with current	S9999		

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