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 11/16/2020

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

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S 000	Initial Comments Complaint Investigation 2082900/IL122038 2086748/IL126186 2088155/IL127751	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to monitor, supervise, and protect four residents (R12, R13, R24, and R25) from serious bodily harm. These failures resulted in R12 sustaining a right hip fracture, R13 sustaining a left knee fracture, R24 sustaining a serious head injury where he suffered a change in condition that required emergency medical services, hospitalization, and intubation, and R25 sustaining a right arm fracture.

Findings include:

1. According to the face sheet, R12 was admitted to the facility on 05/31/2005. R12's diagnoses

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include, but are not limited to seizures, dementia, anxiety, convulsions, depression, right hip fracture and loss of ability to understand or express speech. A Brief Interview for Mental Status indicates that R12 is not cognitively intact and requires extensive to total assistance from staff.
Fall risk assessment dated 03/28/2020 notes that R12 is a high risk for falls and has a history of falls.

Record Review of R12's resident records document the following:

Progress note dated 04/06/2020, notes in part, R12 alert and responsive. Displays pain upon movement of right leg. Also, pain to touch and unable to give range of motion. The doctor was notified of condition. Orders were given to send resident to a local hospital. X-ray report dated 04/08/2020, notes right hip fracture.

Unusual Occurrence Report dated 04/07/2020, notes R12 complained of right leg pain. Pain medication was administered. The medical doctor was notified and R12 was sent to a local hospital. R12 was unable to verbalize how the incident occurred. All staff and residents with contact with R12 were interviewed. R12 was diagnosed with a right hip fracture. The cause of the fracture could not be identified. R12 is noted with a history of impulsive behaviors, poor safety awareness, and noncompliance with using his wheelchair or asking for assistance with transfers. R12's roommates were also interviewed. No reports of seeing or hearing any falls or unusual occurrences.

2. R25's diagnoses include but are not limited to schizophrenia, fracture of right arm, dementia

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with behaviors, difficulty walking, weakness, and psychotic disorder. A review of R25's care plan notes that she is not very alert, is at risk for falls related to impaired mobility with an unsteady gait. R25 presents with an alteration in the ability to communicate due to impaired speech and cognitive abilities. R25 has behaviors that include wandering, pacing, and roaming.

Review of R25's resident records documents the following:

Progress note dated 10/01/2020, notes R25's right shoulder was noted to be bulging out, no injuries witnessed. Resident is cradling affected arm to her side, not compliant, unknown cause at this time. R25 was sent to a local hospital for an x-ray. The x-ray result was a right arm fracture.

On 11/15/2020, at 3:30PM, V31 (Nurse) stated, "A CNA (Certified Nursing Assistant) informed me that R25's shoulder is 'coming off'. I assessed her shoulder and it did not look right. I informed the doctor what was going on. It looked abnormal. R25 ambulates a lot. For residents that are higher risk we try to monitor more closely. If the resident is not alert and oriented, they are not going to remember the safety awareness. She is not very alert and oriented. She is very confused and needs to be monitored."

The surveyor conducted interviews regarding the incidents that occurred on 04/7/2020 and 10/01/2020 involving residents R12 and R25.

On 11/15/2020, at 10:41AM, V24 (CNA) stated, "Staff should be making rounds every two hours. R12 needs more frequent rounding. He will sit up on his own and try to get out of the bed. He is not an independent resident. He cannot get up on his

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own. He is a total care resident with extensive assistance."

On 11/15/2020, at 10:53AM, V23 (Nurse) stated R12 was having seizures. R12 does not talk at all. He is a fall risk and requires more frequent monitoring and supervision.

On 11/15/2020, at 11:30AM, V13 (Licensed Practical Nurse/LPN) stated, "The care plan is supposed to get updated by the nurses. In my opinion, R12 has several predisposing factors such as decreased safety awareness, confusion, incontinence, gait imbalance, impaired memory, and weakness. R12 is not able to speak much. He is not very alert and oriented. He can get up by himself, but he is unsteady. He is a total care resident and he is very confused. He requires supervision."

On 11/15/2020, at 2:50PM, V18 (Quality Assurance/Fall Coordinator) stated, "The care plan needs to be updated after every fall, what may have caused the fall and what we can do to prevent the fall again. R12 was sent out because he complained of pain. This was not reported as a fall that day. R12 tends to be impulsive, needs redirection, and supervision. The predisposing factors in the incident reports should be checked off as part of the investigation."

On 11/15/2020, at 2:25PM, V28 (Medical Doctor) stated, "I am very familiar with R12 and R25. R25's type of arm fracture usually results from a fall. R25 ambulates aimlessly. Staff should be overseeing them and making sure there is enough staff to monitor. R12 is a high risk for fracture due to his osteoporosis. The staff have to be more aware of the residents' risks."

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On 11/15/2020, at 3:14PM, V22 (CNA) stated, "R25 needs to be redirected because she is confused. She is set in her ways. She walks around and is incontinent. She goes in everyone's room. She needs supervision because she takes things and walks around. I am not aware if she is a fall risk. Monitoring every two hours and as needed will help prevent a resident from falling and injuring themselves.

Record review of R12 and R25 assessments and care plans note:

Fall Risk Assessment dated 11/07/2020 notes R12 has had three or more falls in the facility. R12 is frequently incontinent and disoriented. He is still a high risk for falls. After 04/07/2020, R12 had four more falls within the facility. On 05/29/2020, R12 had a fall where he sustained a small cut to his forehead.

R12's care interventions include staff need to anticipate and meet R12's needs, follow the facility fall protocol, increase monitoring and toileting every two hours, review information on past falls and attempt to determine cause of falls, record possible root causes, remove any potential causes if possible, educate resident, family, and caregivers and staff as to the causes, educate the resident, family, care givers about safety reminders and what to do if a fall should occur, be sure the call light is within reach and encourage the resident to use it for assistance as needed, continue interventions on the at-risk plan, place resident in high visual areas while awake and staff provide frequent checks to ensure that all needs and wants are met.

Fall risk assessment dated 08/29/2020 and 10/17/2020 note that R25 is a high risk for falls.

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R25's care plan interventions include anticipate and meet the resident's needs, educate the resident, family, caregivers about safety reminders and what to do if a fall occurs, follow facility fall protocol, review information on past falls and attempt to determine cause of falls, record possible root causes, observe resident for impaired balance, lethargy and implement preventive intervention strategies.

3. R13's diagnoses include hydrocephalus, impulsiveness, mild cognitively impairment, and depressive disorder. R13's cognitive assessment score dated 8/19/20 is 5, which indicates severe cognitive impairment. dated 8/19/20.

During observation of R13 at 10:04AM with V18 (Quality Assurance Nurse), V18 stated R13's call light string is not long enough and should be close to him.

During an interview on 11/14/20 at 11:27AM V13 (Licensed Practical Nurse/LPN) stated, "I keep R13 in my field of vision. R13 used to be in a room where he could be seen more frequently located across from nurses' station. Most of R13's falls occur at shift change."

During an interview on 11/14/20 at 12:06PM V18 stated the care plan should be updated with a new intervention after each fall.

During an interview on 11/14/20 at 1:08PM V12 (LPN) stated R13 fell in his room, located at the end of the hall away from nurses' station, and she was aware of R13's risk for falls. V12 stated, "We monitored him, reinforced for him to call for assist when he wanted to get up. I followed the fall protocol. I was not given further instruction to

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prevent R13 from falling again. We continued to do what we did before." V12 stated any staff interviews she made would have been documented. V12 stated, "I don't know what caused him to fall. I try to do rounds every 2 hours on all my residents."

During an interview on 11/14/20 at 2:12PM V18 stated R13's fall care plan has no intervention following the fall on 6/11/20.

During an interview on 11/14/20 at 2:24PM V22 (CNA) stated, "I take R13 to the bathroom when I see he has started to pull his pants down. When I seem him like that, I know that he was trying to take himself to the bathroom." V22 stated, "I tell R13 to lock his wheelchair when he gets up because we can't be with him at all times." V22 stated R13 can stand, but if he stands up he can fall. V22 stated R13 sometimes remembers the reminders, other times he does not.

During an interview on 11/15/20 at 9:19 AM V18 stated the standard fall precautions from the Fall Prevention Program are used on all residents.

During an interview on 11/16/20 at 10:15AM V34 (Occupational Therapist) stated R13 received physical therapy from 8/13/20 until 8/24/20 and occupational therapy from 8/13/20 until 9/8/20.

During an interview on 11/16/20 at 10:58AM V33 (Therapy Director) stated R13 is a fall risk. V33 stated R13 can recall safety interventions 60-70% of the time; the other times he does not follow them. V33 stated R13 requires one-person assist with transfers.

Review of R13's fall care plan notes intervention date initiated 10/13/18: Be sure the resident's call

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S9999	Continued From page 8 light is within reach. Review of fall report for 8/3/20 notes resident on the floor in bathroom. The intervention noted on care plan dated 8/3/20 states remind to call for assistance, provide toileting assistance every 2 hours and as needed, refer to therapy for screening. Review of R13's assessments include Functional Status assessment dated 8/19/20 which notes R13 requires extensive assistance of one person with bed mobility, transfers, dressing, toileting, and personal hygiene. Balance assessment for moving from seated to standing position dated 8/19/20 notes the resident is not steady, only able to stabilize with staff assistance. Fall history assessment dated 8/19/20 notes a history of a fall in the last month and in the last 2-6 months. Review of fall report for 8/28/20 notes R13 stated, "I slid out of my chair." Intervention dated 8/28/20 states encourage him to come out of his room. Review of R13's fall report on 8/31/20 noted R13 stated his legs give out. Intervention dated 8/31/20 was for a therapy screen. Review of R13's fall report on 9/20/20 notes R13 fell in his room. Review of X-ray reports a knee x-ray was obtained and left knee shows faint linear vertical fracture of patella (knee bone). Review of R13's Fall Risk Review dated 8/31/20 notes R13 has been determined to be high risk for falls. Fall Risk Reviews for 9/20/20, 10/3/20 and 11/14/20 note R13 is determined to be high risk for falls. R13's Fall care plan initiated 10/13/18 notes he is at risk for falls/accidents related to medical complexities, impaired mobility,	S9999		

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incontinence, multiple medication use, history of falling, [and] psychotropic medication use. The focus does not include a fall risk classification of high risk, as mentioned on the Fall Risk Reviews. Interventions of placing the call light in reach are listed on 10/13/18 and 8/3/20. There is no care plan intervention documented following the fall on 6/11/20.

Review of R13's fall care plan notes interventions for therapy screen following falls on 8/3/20 and 8/31/20. As written above, V33 stated R13 began therapy on 8/13/20 and continued on therapy until 9/8/20.

Review of R13's fall care plan notes interventions following the fall on 8/3/20 included remind resident to call for assistance. This intervention had already been added as intervention on 10/13/18 when the fall care plan focus was initiated.

4. R24's diagnoses include but are not limited to residual schizophrenia and vascular dementia.

Review of R24's Fall Report dated 7/7/20 notes R24 fell in the hallway, was unconscious, emergency services called, and the paramedics arrived to the scene.

During an interview at 1:30PM V2 (Director of Nursing) stated R24 did not return to the facility after 7/7/20.

During a phone interview on 11/15/20 at 2:04PM V26 (Family Member) stated, "R24 has expired. He passed away last month. He would always say he wanted to come home. The facility does not monitor these residents or keep them safe." V26 stated R24 fell several times at the facility and hit

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his head. V26 stated they neglected R24.

During an interview on 11/15/20 V25 (CNA) stated R24 needed cues. V25 stated she had seen R24 running in the halls and knew he had dizzy spells in the past.

During a phone interview on 11/16/20 at 12:09PM V18 stated R24 sustained an injury from the fall on 5/21/20 and he received stitches. V18 stated the care plan should have an intervention following his fall on 5/21/20.

During a phone interview on 11/15/20 at 2:18PM V28 (Physician) stated, "I expect the staff to look for the cause of the fall and address it to prevent falls."

Review of R24's Fall Risk Review dated 5/16/20 and 6/6/20 notes R24 is at high risk for falls. R24 was noted to have a history of 1-2 falls in last 6 months.

Review of Fall Report for R24 dated 5/21/20 notes R24 fell in the hallway after running with unsteady gait. Report states resident fell and hit right side of his head. Predisposing factors are unanswered on the report.

Review of R24's care plan for fall focus initiated on 10/13/18 document interventions listed as initiated 10/13/18. The exception was on 11/14/19 when a new intervention was put in place for increased monitoring when ambulating and neuro checks. No intervention was listed following the 5/21/20 fall.

Review of Progress Notes dated 7/9/20, written by V2, state resident was not extubated due to possible myxedema (a condition that occurs

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S9999	Continued From page 11 when your body does not produce enough thyroid hormone). Review of R24's final report sent to IDPH on 7/15/20 states R24 was admitted to the hospital with diagnosis of seizure, head injury, and history of falling. At this time resident remains hospitalized. Further review of R24's care plan does not include R24's behavior of running in halls or being dizzy. The facility's undated Policy for Fall Prevention Program notes the program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementing appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The Fall Prevention Program includes the following components: 10. Care Plan incorporates: identification of all risk/issue. Standards include safety interventions will be implemented for each resident identified at risk using a standard protocol. Standard Falls/Safety Precautions for all residents includes 2. The nurse call device will be placed within the resident's reach at all times. 7. Residents will be observed approximately every 2 hours to ensure the resident is safely positioned in the bed or a chair. 8. Call lights are kept within reach and answered promptly. 16. All nursing personnel will be informed of residents who are at risk of falling. The fall risk classification will be identified on the care plan. Safety Precautions for residents at risk notes any resident who falls at least twice within 30 days will be considered AT RISK. Care Plan incorporates: Identification of all risk/issues. Interventions are changed with each fall, as appropriate. Preventative measures.	S9999		

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