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 09/15/2022

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 FRI of 8/18/2022/IL150654	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	S9999	**Attachment A** Statement of Licensure Violations	

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 09/15/2022

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
S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal 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 upon observation, interview and record review the facility failed to provide supervision, failed to review/revise fall prevention interventions (post fall) and failed to implement fall prevention interventions for two of three residents (R1, R3) reviewed for falls. These failures resulted in R1's (8/18/22) laceration requiring suture repair and R3's (9/9/22) left eye swelling/bruise. Findings include: R1's (7/20/22) BIMS (Brief Interview Mental Status) determined a score of 11 (moderately impaired). R1's (7/20/22) functional assessment affirms supervision is required for transfers and walking.	S9999		

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 09/15/2022

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
S9999	Continued From page 2 R1's (7/16/22) fall risk assessment determined high risk for falls. R1's (8/18/22) initial facility reported incident states resident was observed by activity aid on floor of dayroom, noted blood on his face. Witnessed? No. R1's (8/18/22) final investigation states resident was sent to the hospital for evaluation and repair of laceration to chin (5 sutures). R1's care plan states resident is at risk for falls related to impaired mobility with an unsteady gait, incontinence, psychoactive medication use, and history of falling however the interventions were last reviewed/revised on 6/14/22 (2 months prior to falling) and staff supervision in the dayroom is excluded. On 9/14/22 at 11:02am, surveyor inquired about R1's cognitive status. V3 (Licensed Practical Nurse) stated, he's alert and oriented maybe like 2-3. Surveyor inquired about R1's fall prevention interventions. V3 responded, "Using the call light before he gets up to ambulate or if he needs toileted, bed in low position and floor mats in place overnight." On 9/14/22 at 11:07am, R1 was observed in the dayroom (with seven other residents) however, the dayroom was not supervised by staff and a call light was not present. Surveyor inquired about R1's recent fall R1 proceeded to write symbols on a paper and did not respond. On 9/14/22 at 11:10am, surveyor inquired if the dayroom is supposed to be supervised by staff. V3 stated, "Usually we have activities in there.	S9999		

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 09/15/2022

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
S9999	Continued From page 3 She (Activities Staff) may have stepped out for a second." On 9/14/22 at 11:15am, surveyor inquired about staff supervision in the dayroom. V4 (CNA/Certified Nursing Assistant) stated, "It was activities in there and they (Activities Staff) let no one know that they were leaving." R3's (8/23/22) cognitive assessment affirms daily decision making is severely impaired. R3's (8/23/22) functional assessment affirms extensive assistance is required for bed mobility and toilet use. R3's (8/20/22) fall risk assessment determined high risk for falls. R3's (9/9/22) incident report states resident experienced an unwitnessed fall (in the bedroom). Noted with bruise and swelling to left eye. Predisposing factors confused, impulsive, gait imbalance and decreased strength/endurance. R3's (11/22/19) care plan states resident is at risk for falls related to cognitive/communication deficits. R3's interventions include be sure the resident's call light is within reach however, the interventions were last reviewed/revised on 4/16/22 (roughly 5 months prior to falling). On 9/14/22 at 11:19am, surveyor inquired about R3's fall prevention interventions. V5 (CNA) stated, "They (Staff) use the floor mats for him (R3) and keep the bed kinda low." R3 was lying in bed (in low position) and floor mats were adjacent the bed however the call light was out of reach and on the floor. Surveyor inquired about	S9999		

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 09/15/2022

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
S9999	Continued From page 4 the location of R3's call light. V5 responded, "They (Staff) need to keep it on the bed." On 9/14/22 at 12:51pm, V2 (Director of Nursing) stated, "If we have residents in the dayroom we're supposed to have somebody supervising the dayroom." Surveyor inquired about R1's (8/18/22) fall. V2 responded, "He (R1) was walking in the hallway, he (R1) lost his balance, he (R1) slipped and fell. He (R1) hit his chin which caused a laceration." Surveyor advised that R1's (8/18/22) fall occurred in the dayroom (not the hallway as stated) and inquired about R1's preventive interventions post fall. V2 replied, "We try to have staff make sure that they (staff) are staying in the dayroom with the residents." Surveyor inquired who supervises the dayroom. V2 stated, "We have our shift staff that would help out in the dayroom, activity staff, ancillary staff or anybody we assign there." Surveyor inquired if there's a schedule for staff assigned to the dayroom. V2 responded, "We have an assignment sheet but I'm not sure if there's an assignment for the dayroom, I would have to look." Surveyor inquired about R3's (9/9/22) fall V2 replied "It was an unwitnessed fall they (Staff) were able to get him (R3) back up and get him back into bed. At the time, bed was in the lowest position. He (R3) had some bruising around his nose and forehead." Surveyor relayed concerns regarding R3's call light observed on the floor (while lying in bed). V2 stated, "The call lights are supposed to be in reach that is for sure." The (2/28/14) fall prevention program states safety interventions will be implemented for each resident identified at risk using a standard protocol. Accident/Incident reports involving falls will be reviewed by the Director of Nursing and the IDT (Interdisciplinary Team) to ensure	S9999		

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 09/15/2022

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
S9999	Continued From page 5 appropriate care and services were provided and determine possible safety interventions. Care plan interventions are changed with each fall as appropriate. Call lights are kept in reach. The resident will be checked approximately every two hours, or as or as according to the care plan to assure they are in a safe position. The frequency of safety monitoring will be determined by the resident's risk factors and the plan of care. (B)	S9999		