Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002067			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE
AUSTIN	OASIS, THE		TH AUSTIN B	LVD		
04 ID	SI IMMADV STA	TEMENT OF DEFICIENCIES), IL 60644	DECLEDED DI ANION		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		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		S 000		-	V sa
	Complaint Investiga	tion: 2284809/IL148157				
S9999	Final Observations		S9999			
	Statement of Licensure Violations					
	300.610a)				100	555
	300.1210b)					
57	300.1210c) 300.1210d)5)					
	Section 300.610 Re	esident Care Policies				
	procedures governir		10		* ***	
	administrator, the admedical advisory color nursing and other policies shall comply	dvisory physician or the mmittee, and representatives services in the facility. The with the Act and this Part. shall be followed in operating				*
	the facility and shall	be reviewed at least annually ocumented by written, signed	V%			8
	Section 300.1210 G Nursing and Person	ieneral Requirements for al Care	18	32.0		
	and services to attai practicable physical,	provide the necessary care n or maintain the highest mental, and psychological ident, in accordance with				10 10 10 10 10 10
	each resident's complan. Adequate and care and personal care.	prehensive resident care properly supervised nursing are shall be provided to each total nursing and personal	8	Attachme Statement of Licens		12

STATE FORM

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ COMPLETED C IL6002067 B. WING 07/12/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH AUSTIN BLVD **AUSTIN OASIS, THE** CHICAGO, IL 60644 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection. and prevent new pressure sores from developing. These Requirements were NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure that the Low Air Mattress was set at the recommended settings: failed to ensure the Low Air mattress were not layered with multiple linens and padding; failed to identify a pressure ulcer on a resident who was assessed and coded at high risk for pressure ulcer. This failure affected two of three residents (R1 and R3) reviewed for pressure ulcer care and prevention in the sample. As a result, R3 developed a new facility acquired pressure ulcer that went unidentified and treated until it was unstageable.

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S9999	Continued From page 2		S9999								
iš	with V12 and V25 C R3 was noted in bed a disposable inconti	00pm, during incontinent care NA (Certified Nurse's Aides), don an air loss mattress with nent pad, a facility clothes a draw sheet linen in the bed.	×	A greater							
;#:	When the survey as Nurse's Aide) about with a resident using became upset telling	ked V12 CNA (Certified how the bed should be made an air loss mattress. V12 the surveyor that, the per nervous. V12 did not				2.5					
	with V2 DON (Director R3 was noted with a right feet and toes with measured 4cm by 2cm unstageable. Both V2 present any document has been addressed, for V7 (wound care Now wound site. V2 stated assist in performing to (V7) works in two of the process of the stated the stated was noted.	3's wound care observation or of Nurse's) and V8 (RN), new skin alteration to the ith blackish color that it (centimeter) and 2 and V8 could not explain or ntation showing where this V8 told the surveyor to wait lurse) explanation on the 1 V7 was in another facility to the wound care. V2 stated their facility as a wound care icensed nurses on the floor pass will have to assist in			×:	49					
	use of Santyl ointmen (Collagenase) apply to every-day shift for woo (Normal saline). Apply cover with gauze and the Santyl Ointment, a	o right hip topically und healing cleanse with NS y Santyl to wound bed, xeroform. V8 searched for and it was unavailable. V2 ent medication should not									

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resident should be written on the feeding bottle. Regarding the open wound pressure ulcer site

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