STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145834	A. BUILDING _____ B. WING _____	09/01/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a clean, comfortable, homelike environment on the 3rd floor. This failure has the potential to affect 49 (3rd floor) residents. Findings include: The (8/24/20) census includes 49 (3rd floor) residents. On 8/24/20 at 1:40pm, a strong urine order permeated the (3rd floor) hallway. On 8/24/20 at 1:43pm, R1's bedroom floor was visibly soiled with dirt and debris. Surveyor's shoes adhered to the floor while inspecting his room. On 8/24/20 at 1:47pm, surveyor inquired about the odor in the 3rd floor hallway. V5 (Certified Nursing Assistant) stated I smell urine. I think it just needs to be mopped. Surveyor inquired about the substances on R1's bedroom floor. V5 stated That looks like something white, like some icing or something and there's dirt. Surveyor inquired why R1's floor was sticky. V5 responded It needs to be mopped better; that's part of the smell. On 8/24/20 at 1:55pm, surveyor inquired about the (3rd floor) housekeeping. V6 (Floor Tech) stated Basically I do floors; I strip and wax floors. The housekeeper is not here today. Surveyor inquired about the substances on R1's bedroom floor. V6 stated I see food and stuff like that. I see fingernail polish. Surveyor inquired about the required frequency for cleaning resident rooms. V6 responded They're supposed to clean them every day. On 8/24/20 at approximately 2:00pm, additional concerns were identified: debris was on the floor in room [ROOM NUMBER], dirt was on the floor in room [ROOM NUMBER], debris and dirt were on the floor in room [ROOM NUMBER], dirt was on the floor and a bedside table was visibly soiled/sticky in room [ROOM NUMBER], an open ketchup packet was on the floor adjacent the (3rd floor) nurses station and the hallway floor was also sticky. The (7/14) housekeeping guidelines state housekeeping personnel shall adhere to daily cleaning assignments developed so to maintain the facility in a clean and orderly manner. All horizontal surfaces will be cleaned daily and as needed.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** Based on observation, interview and record review the facility failed to provide ADL (Activities of Daily Living) care to one of 3 residents (R1) reviewed for ADL's. Findings include: On 8/24/20 at approximately 1:50pm, R1's hair and beard were long and unkempt. Surveyor inquired about R1's ADL care, however he did not respond. Surveyor inquired about R1. V5 (Certified Nursing Assistant/CNA) stated He won't talk to you, but he'll let you check him. Surveyor requested to inspect R1's incontinence brief. V5 responded I tried to check him earlier, but he refused. I just came out of the room maybe like 10 minutes ago. Surveyor inquired when R1's brief was last changed. V5 responded When I got here at 7:00am. Surveyor inquired about the required frequency of incontinence care. V5 stated I check them as needed. I believe it's like every hour or so. V5 requested R1 stand for the inspection; R1 complied (he did not refuse). V5 inspected R1's backside and stated It's bowel movement in there. A large bowel movement was present and R1's pull up was completely saturated with urine. On 8/31/20 at 1:22pm, a strong urine odor was noted when surveyor approached R1. R1 was sitting on the bed with a large dried yellow substance on the sheet beneath him. R1's fingernails and toenails were long with a black substance beneath them. Surveyor inquired about R1's appearance. V18 (CNA) stated R1's nails need to be cut and cleaned up. His hair needs to be cut and his beard needs to be shaved. Surveyor inquired when R1's pull-up was last changed. V18 responded He was changed like .I don't even know what time. I'm gonna tell you the honest truth. Surveyor inquired about the dried yellow substance on the sheet (beneath R1). V18 stated That's a pee spot. The (9/14) incontinency care policy states incontinent resident will be checked periodically every two hours and provided perineal and genital care after each episode. The (4/14) ADL policy includes grooming: maintaining personal hygiene including combing hair, shaving, and nail care.
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to notify the physician of resident change in condition, failed to obtain vital signs, failed to document a physical assessment, failed to implement an incident report, and failed to provide timely care/services for one of three residents (R1) reviewed for change in condition. These failures resulted in R1 sustaining severe pain related to left femoral neck fracture. Findings include: On 3/22/20, V10 (Licensed Practical Nurse/LPN) documented in the progress notes that staff on duty informed her that (R1) was noted to have facial grimacing while being changed. Writer assessed and Tylenol given as ordered for pain. (R1's 3/22/20 Medication Administration Record [REDACTED]. Staff will continue to monitor and follow up as needed. (There is no documentation regarding vital signs and/or physician notification.) On 8/26/20 at 9:56am, surveyor inquired about R1's cognitive status. V10 stated Usually he's sitting up making facial expressions. He's not able to talk, he makes like moaning expressions. Surveyor inquired about R1's (3/22/20) assessment. V10 stated One of the staff members came to me with concern that he may be having possible pain. He had a facial grimace with some pain and discomfort, I really couldn't tell where. When I went to assess him, he wasn't guarded or anything but that was not the norm for him. Surveyor inquired if she filled out an incident report (on 3/22/20). V10 affirmed We did not; we did not know at that time what was going on. I wasn't informed to do one at that time with the manager on duty. R1's (3/25/20) summary of investigative findings states on 3/22/20, nurse observed resident in pain, assessed and noted change in range of motion to left lower extremity. On 3/23/20, V11 (LPN) documented in the progress notes that (R1's) left knee and ankle x-ray was performed. Will continue to monitor. (There is no documentation regarding vital signs, physical assessment, and/or x-ray results). On 8/25/20 at 3:39pm, surveyor inquired why R1 required knee/ankle x-rays (on 3/23/20). V11 stated I was told to carry out that order from the 24-hour report. Surveyor inquired why R1's (3/23/20) physical assessment and/or vital signs were not documented. V11 responded I wasn't aware I had to fill out a separate assessment for each patient. Surveyor inquired if she documented an incident report for R1 (on 3/23/20). V11 replied No. Why would I fill out an incident report if I didn't know if he fell , if he didn't fall on my shift and I didn't witness it? Surveyor inquired when an incident report is required. V11 responded To my knowledge if there's a fall or if the patient is injured. R1's Physician order [REDACTED]. R1's (3/24/20) Medication Administration Record [REDACTED]. R1's (3/24/20) femur/hip x-ray includes reported date and time 3/24/20 at 5:58pm. R1's (3/25/20) SBAR

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) (Situation Background Assessment Recommendation) affirms he was not transferred to the hospital until approximately 12:00pm (18 hours after the fracture was reported). R1's (3/25/20) History & Physical states the patient was brought to the emergency room for inability to ambulate with severe left-sided pain. X-rays and CT (Computed Tomography) shows non-displaced (left) femoral neck fracture. On 9/1/20 at 12:30pm, surveyor inquired about R1's aforementioned injury. V20 (Physician) stated R1 went out to the hospital for a [MEDICAL CONDITION] and they did surgery. R1's (3/29/20) discharge summary states: patient underwent percutaneous screw fixation of left femoral neck fracture. On 9/1/20 at 12:30pm, surveyor inquired about nursing requirements for R1's (3/22/20) change in condition. V20 (Physician) stated They should contact the physician if there's any change in condition. They should do vital signs. If the patient is having pain that should be assessed. If there was an incident on the 22nd or any kind of pain they should have notified me to get orders for an x-ray. I would never wait on ordering an x-ray. Surveyor inquired about potential harm to R1 if care/services were not provided and/or timely (on or about 3/22/20). V20 responded Compromised care if the physician is not notified right away. If he's in pain that might also be a problem. The (11/14) pain management program states pain assessment protocol will be initiated under the following situation: a change in resident condition occurs to require pain control. Documentation of assessments and the resident's response to the pain management plan will be made with each assessment. The (4/14) change in condition physician notification guidelines state these guidelines were developed to ensure that: all significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and to be documented in the medical record. When contacting the physician the nurse in charge should have the following information available: nature of problem or complaint with symptoms, signs, and results of current physical assessment, including vital signs and mental status. Any calls to or from the physician will be documented in the nurse's notes indicating information conveyed and received.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that staff are aware of resident fall prevention interventions and failed to implement fall prevention interventions for two of three residents (R1, R5) reviewed for falls/injury. Findings include: R1's (3/25/20) History & Physical states the patient was brought to the emergency room for inability to ambulate with severe left-sided pain. X-rays and CT (Computed Tomography) shows non-displaced (left) femoral neck fracture. On 9/1/20 at 12:30pm, surveyor inquired about R1's aforementioned injury. V20 (Physician) stated R1 went out to the hospital for a [MEDICAL CONDITION] and they did surgery. R1's (3/29/20) discharge summary states: patient underwent percutaneous screw fixation of left femoral neck fracture. R1's (3/25/20) unusual occurrence final investigative report states resident possibly fell from bed. R1's (12/8/18) care plan includes potential risk for falls/accidents related to impaired mobility, cognitive/communication deficits, and receiving [MEDICAL CONDITION] medication. Intervention: Be sure resident's call light is within reach. On 8/24/20 at 1:43pm, R1 was lying in bed and his call light was on the floor. V5 (Certified Nursing Assistant) subsequently entered and exited R1's room without providing the call light. R5's (3/31/20) incident report states resident fell to the floor. Resident stated she was trying to get out of bed and fell . R5's (12/26/18) care plan includes risk for falls/accidents related to history of falling, [MEDICAL CONDITION] medication use and impaired mobility with unsteady gait. Intervention: be sure the resident's call light is within reach. On 8/24/20 at 2:10pm, R5 was lying in bed without call light access. V7 (Licensed Practical Nurse) entered R5's room and administered medication. Surveyor inquired about R5's fall prevention interventions. V7 stated It's my 2nd week here; I don't know yet and exited the room. The (2/28/14) fall prevention program states all assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained. Standard fall/safety precautions for all residents: The nurse call device will be placed within the resident's reach at all times.