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 _____	**03/06/2020**

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.

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F 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to report suspicion of a crime for 1 of 1 resident (R1) in the sample of 3 (R1, R3 and R6) reviewed for abuse and physical assault. Findings include: On 3/3/20 at 1:05 PM R1 was observed inside R1's room with right leg cast from above the knee to foot, exposing only the toes. R1 was grimacing and moaning; R1 was unable to move her right leg. R1 was alert and oriented to person, place and time, with a Brief Interview for Mental Status (BIMS) score of 13. R1 stated that she suffered severe pain and has not been able to move her right leg since it was twisted by R3. R1 stated that the pain was getting worse and worse and that R1 could not sleep well at night. R1 stated R1 has a fracture which was caused by her roommate (R3) when R3 grabbed her leg and squished it as hard as she could while she was sitting in her wheelchair. R1 stated that no one saw what happened because they were alone during the incident. On 3/3/20 at 1:30 PM R3 was observed inside the 3rd floor dining room sitting in a wheelchair. R3 stated that she was living on the 2nd floor before and had a fight with her roommate (R1). R3 stated that she grabbed R1's leg and pulled and twisted it. R3 stated she doesn't think she broke R1's leg but just twisted it. R3 stated the fight started over R3 wanting to buy some pizza, but R1 did not want to give R3 money. On 3/4/20 at 11:56 AM V1 (Administrator) stated that R1 stated that her roommate (R3) twisted her leg. R3 was sent to the hospital for psych evaluation and was admitted . V1 stated that no nursing staff witnessed the incident. V1 stated that he was not in the facility when the incident happened. V1 received a call from V6 (Nurse Supervisor) that R1 was complaining of pain on the leg and that pain medication was given. On 3/4/20 at 4:00 PM. V4 (Registered Nurse) stated, I was taking care of R1 the day of the incident. Later during the shift, R1 complained of right knee pain. R1 stated that R3 messed with her leg by twisting it. R1's right leg was swollen during assessment, V6 (Nurse Supervisor) instructed me to give pain medication and to inform V8 (Attending Physician). V8 was informed and ordered an X-Ray. R1's Progress Notes dated 2/12/20 read that a portable X-Ray was done in the facility on R1's right leg due to pain and swelling. V1 (Administrator), V2 (Director of Nursing) and V8 (Attending Physician) were informed. On 2/13/20 V8 (Attending Physician) was informed of the X-Ray result. Right leg X-Ray result dated 2/12/20 read: Findings: There was an acute mildly displaced comminuted fracture distal tibia and fibula. Normal ankle mortise. Impression: Acute mildly displaced comminuted fracture distal tibia and fibula. R1's medical [DIAGNOSES REDACTED]. Police report provided by V1 (Administrator/Abuse Coordinator) does not include the name of Victim/Complainant. The police report was dated 2/14/20 1:30 PM, two days after the incident. Incident read: Battery - Simple. V1 stated that he would call the police station to ask for a final copy of the police report. After multiple requests, no report was provided. Policy for Abuse Prevention Program dated 11/22/17 reads: V. Reporting and Response B. Police. The administrator or designee shall notify the local police of any suspicion of a crime or in the event of resident death other than disease process.
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 provide immediate medical attention for a right leg fracture to 1 out of 1 resident (R1) in the sample of 4 (R1, R2, R4 and R 5) reviewed for nursing care. This failure resulted in severe pain to R1's right leg fracture. Findings include: On 3/3/20 at 1:05 PM R1 was observed inside R1's room with right leg cast from above the knee to foot, exposing only the toes. R1 was grimacing and moaning; R1 was unable to move her right leg. R1 was alert and oriented to person, place and time, with a Brief Interview for Mental Status (BIMS) score of 13. R1 stated that she suffered severe pain and has not been able to move her right leg since it was twisted by R3. R1 stated that the pain was getting worse and worse and that R1 could not sleep well at night. R1 stated R1 has a fracture which was caused by her roommate (R3) when R3 grabbed her leg and squished it as hard as she could while she was sitting in her wheelchair. R1 stated that no one saw what happened because they were alone during the incident. On 3/3/20 at 1:30 PM R3 was observed inside the 3rd floor dining room sitting in a wheelchair. R3 stated that she was living on the 2nd floor before and had a fight with her roommate (R1). R3 stated that she grabbed R1's leg and pulled and twisted it. R3 stated she doesn't think she broke R1's leg but just twisted it. R3 stated the fight started over R3 wanting to buy some pizza, but R1 did not want to give R3 money. On 3/4/20 at 11:56 AM V1 (Administrator) stated that R1 stated that her roommate (R3) twisted her leg. R3 was sent to the hospital for psych evaluation and was admitted . V1 stated that no nursing staff witnessed the incident. V1 stated that he was not in the facility when the incident happened. V1 received a call from V6 (Nurse Supervisor) that R1 was complaining of pain on the leg and that pain medication was given. On 3/4/20 at 2:04 PM V8 (Attending Physician) stated that he was informed by the nurse on 2/12/20 that R1 had right leg pain and swelling. V8 stated that he ordered an X-Ray and was informed that R1 had a fracture on her right leg. V8 stated that he ordered the nurse not to send R1 to emergency department or to the hospital but to schedule R1 to see V9 (Orthopedic Physician) in an outpatient orthopedic clinic. V8 stated that if he sent R1 to emergency department or to the hospital they would do nothing but refer R1 to an Orthopedic Specialist. On 3/4/20 at 3:10 PM V2 (Director of Nursing) stated that R1 was not sent to the ER because V8 (Attending Physician) ordered the facility not to send R1 to ER. According to V8, all they would do in the ER is to refer R1 to an orthopedic doctor. So instead V8 wanted to refer R1 directly to an orthopedist. V2 stated that the orthopedic walk-in clinic was open on Saturdays only and because of insurance issues, transportation was not available for R1 to see V9 until 2/22/20. V8 was informed that R1 was scheduled to see V9 on 2/22/20. V2 stated, From 2/10/20 to 2/22/20 we gave R1 pain medication as an intervention. But I do not recall other interventions; I would have to look it up. V2 stated that she spoke to V8 about faxing his progress notes and documentation about R1's incident because V8 has no written documentation of his multiple visits that can be found in the Progress Notes. On 3/4/20 at 3:35 PM V6 (Nursing Supervisor) stated, V4 (Registered Nurse) called and informed me that R1 was complaining about leg pain. We assessed R1 and saw that her knee was swollen. Then V4 gave her pain pill. I instructed V4 to call V8 (Attending Physician) and V8 ordered an X- Ray. R1 stated that her roommate (R3) said that R1 stole her money. R1 said that R3 messed up her knees. Since that is abuse, I called the administrator. V1 (Administrator) told me to call the psych doctor for R3. The psych doctor ordered that R3 be sent to the hospital for psych evaluation. R3 was sent to the hospital and was admitted . On 3/4/20 at 4:00 PM V4 (Registered Nurse) stated, I was taking care of R1 the day of the incident. Later during the shift,

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) R1 complained of right knee pain. R1 stated that R3 messed with her leg by twisting it. R1's right leg was swollen during assessment. V6 (Nurse Supervisor) instructed me to give pain medication and to inform V8 (Attending Physician). V8 was informed and ordered an X-Ray. Right leg X-Ray result dated 2/12/20 read: Findings: There was an acute mildly displaced comminuted fracture distal tibia and fibula. Normal ankle mortise. Impression: Acute mildly displaced comminuted fracture distal tibia and fibula. On 3/6/20 at 1:08 PM V9 (Orthopedic Surgeon) stated, When I saw R1 in my clinic on 3/22/20, I did my assessment and an X-Ray was done. Based on physical examination, R1 was unable to move the right leg and was observed with green and blue bruising. R1 was complaining of severe pain of 10 on a 1-10 pain scale. R1's X-Ray result revealed that R1 had a complete fracture on her right tibia and fibula and right ankle. It is very important to provide immediate medical attention when a fracture happens. There are many complications that may happen. The skin may break open because bones are rough or sharp on the edges. For sure a fracture like this needs immediate medical attention. At the very least it would need a splint. On the X-Ray, R1's ankle showed a complete fracture, as shown in my report. I do not know why on the facility X-Ray, the result was normal ankle mortise. V9's (Orthopedic Surgeon) report dated 2/22/20 read: Physical Exam: R1 was unable to move right leg, green/blue ecchymosis at right knee, right knee appears to be displaced. Right tibia/fibula x-ray - complete fracture. Right ankle 3 view x-ray - complete fracture. Right knee 3 view x-ray - will be reviewed at next appointment. Procedure: Long leg cast application. R1's Minimum Data Set (MDS) assessment dated [DATE] reads: Brief Interview for Mental Status (BIMS) score as 13. R1's needs 2-person extensive on bed mobility and 2-person total assist on transfers. R1 cannot ambulate and uses wheelchair for locomotion. R1's Care Plan does not include any interventions done or updated from 2/12/20 to 2/22/20 for right leg fracture. Updated interventions, which were done after 2/22/20, include altered comfort level for [DIAGNOSES REDACTED]. From 2/12/20 to 2/22/20 R1 had no Care Plan Focus, Goal and Intervention addressing R1's right leg fracture. Policy on Change in Condition Physician Notification Overview Guidelines dated 4/14 reads: All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and is to be documented in the medical records.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide treatment as ordered by Physician of pressure wounds to 3 (R2, R4 and R5) out of 3 residents reviewed for pressure wound treatment and prevention in the sample of 3. These failures have the potential for worsening of R4 and R5's pressure wound. Findings include: During facility tour dated 3/3/20 at 2:01 PM R4 was observed in bed lying on his back. R4 was unable to be interviewed due to orientation. R4 had a dressing on his sacral area. R4's upper and lower extremities were contracted. During facility tour dated 3/4/20 at 10:58 AM R5 was observed with nursing staff doing bedside care. R5 was unable to be interviewed due to orientation. R4 did not respond to questions being asked. 1. R2's Progress Notes dated 1/10/20 read that R2 was transferred to the hospital on the same day. R2's Death Certificate dated 1/12/20 read that cause of death [MEDICAL CONDITION] and [MEDICAL CONDITION]. R2's Progress Notes dated 1/6/20 by V5 (Nurse Practitioner) read that during assessment of R2's sacrum pressure wound a foul odor noted. Pressure wound was malodorous with slough, which was reported to the Wound Nurse. R2's Progress Notes dated 11/22/19 read sacrum wound that was sheared or excoriated became a pressure wound. According to V2 (Director of Nursing) R2 was in the hospital from 11/4/19 to 11/19/19. Admission skin assessment dated [DATE] was requested but none was provided. R2's Treatment Administration Record for 11/2019 shows an order for [REDACTED]. R2's Treatment Administration Record for 12/2019 shows that order for [MED] 250 Unit/Gram to Sacrum daily and as needed was not recorded as done on 12/3/19, 12/21/19, 12/22/19, 12/28/19. R2 was transferred to the hospital from 12/4/19 to 12/19/19. R2's Treatment Administration Record for 1/2020 shows that order for [MED] 250 Unit/Gram to Sacrum was not recorded as done on 1/1/20, 1/3/20, 1/4/20, 1/5/20. R1's Treatment was discontinued on 1/7/20. R2's Facility's Weekly Skin Alteration Review (Wound Nurse) dated 12/26/19 and 1/2/19 read that R2's sacral pressure wound deteriorated. R2's Wound Evaluation and Management Summary by V11 (Wound Doctor) dated 12/19/19 and 1/2/20 read that R2's sacral pressure wound deteriorated and there was an increase in wound size (from 6.3 x 12.4 x 0.4 centimeter (cm) to 9.1 x 14.7 x 1.2 cm) and Surface Area of 78.12 cm to 133.77 cm. 2. R4's Care Plan dated 1/16/20 reads: Administer Wound Care Treatments per MD orders (See Treatment Administration Record for current orders). R4's Treatment Administration Order for 12/2019 shows that order for [MED] 250 unit/Gram with [MED] daily and as needed started on 12/6/19 and ended on 1/8/20. Treatment was not recorded as done on 12/14/19, 12/15/19, 12/21/19, 12/22/19 and 12/28/19. R4's Treatment Administration Record for 1/2020 shows an order for [REDACTED]. Same order for R4's Treatment was ordered with start date on 1/9/20 and ended on 1/24/20. Treatment was not recorded as done on 1/11/20, 1/11/20, 1/18/20 and 1/19/20. Same order for R4's Treatment was ordered with start date 1/25/20 and ended on 2/3/20. Treatment was not recorded as done on 1/25/20, 1/26/20, 1/29/20. R4's Treatment Administration Record for 2/2020 for the order for [MED] 250 Unit/Gram with [MED] to Sacrum daily and as needed. Treatment was not recorded as done on 2/1/20 and 2/2/20. This treatment was discontinued on 2/3/20. R4's treatment to sacrum pressure wound was changed to cleanse with Normal Saline and apply [MEDICATION NAME] Gel 1%, then Santyl after cleansing with normal saline with start date 1/31/20 and ended on [DATE]. Treatment was not recorded as done on 2/1/20, 2/3/20. R4's treatment to sacrum pressure wound was changed to cleanse with Daikin Solution and apply [MEDICATION NAME] Gel 1%, then Santyl with start date 2/7/20 and ended on 2/14/20. Treatment was not recorded as done on [DATE], 2/9/20, 2/12/20 and 2/13/20. R4's treatment to sacrum pressure wound was changed to cleanse with Daikin Solution and apply [MEDICATION NAME] Gel 1%, then [MED] with start date 2/15/20 with no stop date. Treatment was not recorded as done on 2/15/20, 2/16/20, 2/17/20, 2/21/20, 2/23/20, [DATE] and 2/25/20. 3. During facility tour dated 3/4/20 at 10:58 AM R5 was observed in room with nursing staff doing bedside care. Dressing on the sacral area was observed with V3 (Wound Coordinator). R5 was unable to be interviewed. Minimum Data Set Assessment read that R5's Brief Interview for Mental Status (BIMS) dated 2/12/20 was 3. R5's Care Plan dated 10/17/18 read: Administer Wound Care Treatments per MD orders (See Physician order [REDACTED]. R5's Treatment Administration Order for 10/2019 shows that order for [MED] after cleansing with Normal Saline daily and as needed started on 9/6/19 and ended on 12/5/19. Treatment was not recorded as done on 10/2/19, 10/3/19, 10/4/19, 10/5/19, 10/6/19, 10/13/19, 10/19/19, 10/20/19 and 10/22/19. R5's Treatment Administration Order for 11/2019 shows that order for [MED] after cleansing with Normal Saline daily and as needed treatment was not recorded as done on 11/2/19, 11/3/19, 11/9/19, 11/10/19, 11/11/19, 11/16/19, 11/17/19, 11/18/19, 11/23/19, 11/24/19, 11/25/19, 11/29/19 and 11/30/19. R5's Treatment Administration Order for 12/2019 shows that order was changed for [MED] with Silver after cleansing with Normal Saline daily and as needed started on 12/6/19 with no stop date. Treatment was not recorded as done on 12/10/19, 12/14/19, 12/15/19, 12/21/19, 12/22/19, 12/28/19 and 12/31/19. R5's Treatment Administration Order for 1/2020 shows that order was changed for [MED] with Silver after cleansing with Normal Saline daily and as needed treatment was not recorded as done on 1/1/20, 1/3/20, 1/4/20, 1/5/20, 1/8/20, 1/11/20, 1/12/20, 1/18/20, 1/19/20, 1/25/20, 1/26/20, 1/29/20 and 1/31/20. R5's Treatment Administration Order for 2/2020 shows that order was changed for [MED] with Silver after cleansing with Normal Saline daily and as needed treatment was not recorded as done on 2/1/20, 2/2/20, [DATE], 2/9/20, 2/12/20, 2/13/20, 2/15/20, 2/16/20, 2/17/20, 2/18/20, 2/21/20, 2/23/20, [DATE] and 2/25/20. R5's Wound Evaluation and Management Summary by V11 (Wound Doctor) dated 2/3/20 read that R5's sacral wound deteriorated. On 3/4/20 at 9:38 AM V10 (Licensed Practical Nurse) stated that she saw R4's sacral pressure wound about 2 weeks ago because it was the wound care team that performed all dressing changes and assessments. During that time the sacral wound had a green drainage and a foul odor. R4 was also incontinent of both bowel and bladder. On 3/5/20 at 12:50 PM V3 (Wound Coordinator) stated, I don't work on weekends and I don't know if they are doing the dressing changes on weekends. It is usually the nurse on the floor who does the dressing changes on weekends. There is a wound infection when the color of the drainage is not clear and there is a foul odor. I cannot account for the wounds in the past because I just started last Monday. Facility Policy on Pressure Injury and Skin Condition assessment dated reads: 22. Physician ordered treatments shall be initialed by the staff on the Treatment Administration Record AFTER each administration. Other nursing measures not involving medications shall be documented in the progress notes.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide adequate flushing of Enteral Feeding for 1 of 1 resident (R2) in the sample of 4 (R1, R2, R4 and R5) reviewed for nursing care. This failure had the potential for R2's hydration status to decline. Findings include: Treatment Administration Record for 10/2019 read that R2 had no order for

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F 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) flushing from 10/10/19 to 11/19/19. Dietary Progress Note dated 9/3/19 read that R2 was receving Tube Feeding, NPO or does not take anything though mouth, 581 ml free water and 800 ml water flush (200 ml water every 6 hours) = 1381 ml. Dietary Progress Note dated 11/22/19 read that R2 was to have 200 ml water flushes every 2 hours. Dietary Progress Note dated 12/18/19 read that R2 was to have 200 ml water flushes every 2 hours. Laboratory Report dated 11/4/19 reads the following results: Glucose546, Reference Range 64 - 112 Blood Urea Nitrogen 112, Reference Range 5.0 - 28.0 Creatinine, Serum 3.7, Reference Range 0.6 - 1.2 R2's Progress Notes dated 11/4/20 read that R2 was lethargic and somnolent with blood glucose monitoring result of 466. R2's laboratory results relayed to V8 (Attending Physician). V8 (Attending Physician) ordered to send R2 to hospital ER for elevated Blood Urea Nitrogen, Creatinine and Blood Glucose. On 3/5/20 at 1:00 PM V2 (Director of Nursing) stated that there should be an order for [REDACTED].
F 0711 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.** Based on interview and record review the facility failed to make sure that Progress Notes were written, signed and dated by Attending Physician during each visit for 1 out of 1 resident (R1) reviewed in the sample of 6 (R1, R2, R3, R4, R5 and R6). These failures have the potential for lack of correct nursing care. Findings include: On 3/3/20 at 1:05 PM R1 was observed inside R1's room with right leg cast from above the knee to foot, exposing only the toes. R1 was grimacing and moaning; R1 was unable to move her right leg. R1 was alert and oriented to person, place and time, with a Brief Interview for Mental Status (BIMS) score of 13. R1 stated that she suffered severe pain and has not been able to move her right leg since it was twisted by R3. R1 stated that the pain was getting worse and worse and that R1 could not sleep well at night. R1 stated R1 has a fracture which was caused by her roommate (R3) when R3 grabbed her leg and squished it as hard as she could while she was sitting in her wheelchair. R1 stated that no one saw what happened because they were alone during the incident. On 3/4/20 at 2:04 PM V8 (Attending Physician) stated that he was informed by the nurse on 2/12/20 that R1 had right leg pain and swelling. V8 stated that he ordered an X-Ray and was informed that R1 had a fracture on her right leg. V8 stated that he ordered the nurse not to send R1 to emergency department or to the hospital but to schedule R1 to see V9 (Orthopedic Physician) in an outpatient orthopedic clinic. V8 stated that if he sent R1 to emergency department or to the hospital they would do nothing but refer R1 to an Orthopedic Specialist. On 3/4/20 at 3:10 PM V2 (Director of Nursing) stated that R1 was not sent to the ER because V8 (Attending Physician) ordered the facility not to send R1 to ER. According to V8, all they would do in the ER is to refer R1 to an orthopedic doctor. So instead V8 wanted to refer R1 directly to an orthopedist. V2 stated that the orthopedic walk-in clinic was open on Saturdays only and because of insurance issues, transportation was not available for R1 to see V9 until 2/22/20. V8 was informed that R1 was scheduled to see V9 on 2/22/20. V2 stated, From 2/10/20 to 2/22/20 we gave R1 pain medication as an intervention. But I do not recall other interventions; I would have to look it up. V2 stated that she spoke to V8 about faxing his progress notes and documentation about R1's incident because V8 has no written documentation of his multiple visits that can be found in the Progress Notes. V8's Progress Notes were not provided until 3/5/20 and read that multiple dates had been uploaded on the same date (3/5/20) as follows: Tuesday, 2/25/20 Tuesday, 1/14/20 Tuesday, 2/11/20 Tuesday, 1/7/20 Tuesday, 3/3/20 All documentation was not available until 3/5/20 when all notes were uploaded at the same time. Policy on Change in Condition Physician Notification Overview Guidelines dated 4/14 reads: All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and is to be documented in the medical records.