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 09/01/2020

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 2082516/IL121618 2084561/IL123787	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2) 300.1210d)3) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health

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S9999	Continued From page 1 each resident's comprehensive resident care plan. Adequate and properly supervised nursing 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: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 are not met as evidenced by: 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.	S9999		

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S9999	Continued From page 2 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 affirms pain was rated "0" and Tylenol administration was not documented]. 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,	S9999		

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S9999	Continued From page 3 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 for "x-ray of the left lower extremity one time only for pain" was not received until 3/24/20. [There is no documentation of R1's physical assessment, vital signs, x-ray results, and/or physician notification on 3/24/20 in the progress notes]. R1's (3/24/20) Medication Administration Record affirms his pain level was rated "6" at 9:30am. 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 (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.	S9999		

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S9999	Continued From page 4 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 hip fracture 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	S9999		

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S9999	Continued From page 5 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. (B)	S9999		