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 10/26/2020

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 2088285/IL127891	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1010h) 300.1010i) 300.1210b) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. 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	

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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. 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: 1. Based on interview and record review the facility failed to ensure that residents were free of abuse/physical assault. The facility failed to ensure a timely physician notification regarding a resident sustaining a traumatic eye injury and failed to send the resident to the hospital in a timely manner. This affected two (R1 and R3) of three residents, reviewed for abuse and quality of care, resulting in R1 sustaining an eye globe rupture that required surgery. In addition, R3 sustained scratches to the face. The Physician or Nurse Practitioner were not notified until after seven hours, and R1 was not sent to the hospital until about fourteen hours after the injury. 2. Based on interview and record review, the facility failed to adequately supervise and monitor a resident who has a history of physically assaulting other residents. This failure affected one of one resident (R2) reviewed for supervision. R2 went into the rooms of two other residents and physically abused them, injuring his new roommate on the eye, which resulted in a globe rupture of the eye that required surgery. Findings include:	S9999		

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S9999	Continued From page 2 On 10/19/20 at 10:15am, V1 (Administrator) stated that R1 was hit on the eye by another resident. V1 stated that R2 was moved to the third floor and became physically aggressive toward three other residents. V1 added not all the three residents involved in the physical assault were R2's roommates. At this time, V1 presented the facility's preliminary incident investigation report that states that there was a resident to resident altercation on 10/16 20 at 8:50pm where R2 injured R1 and R3. On 10/20 20 at 11:50am, V13 (Certified Nurse Assistant/CNA) stated, "When I went into R1's room to help his roommate get in bed on 3-11 shift around 8:30pm, R1 told me that R2 hit him in the eye. I did not witness the incident. I went to tell the nurse immediately. That day, I worked a double (3-11 and 11-7 shifts). No, R1 was not sent to the hospital on the 3-11 shift or 11-7 shift. I am not sure when he was sent to the hospital, but not on my shift." On 10/19/20 at 11:10am, V16 (Registered Nurse/RN) stated that no staff witnessed the physical altercation between the residents. V16 added, "The staff noticed that R1's eye was swollen, and he said that R2 hit him in the eye." On 10/20/20 at 4:07pm, V15 (Nurse Practitioner) was interviewed regarding the delay in sending R1 to the hospital for treatment. V15 stated, "I'm very familiar with the resident. I expect that the resident be sent out by 911 immediately. There should be no delay because you may not see blood on the eye at first, but it could be internal bleeding since it's the eye." On 10/17/20, V20 (Hospital ER Physician) stated that R1 was sent to the hospital for a Level 2 Trauma. R1's progress notes dated 10/17/20 at 4:33am	S9999		

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S9999	Continued From page 3	S9999		

written by V6 (Wound Care Nurse) states, "Resident received with swollen bloody eye. Resident stated that his new roommate hit him in the eye. Resident is alert. Blood noted to bed." R1's progress notes dated 10/18/20 at 2:25pm written by V10 (Licensed Practical Nurse/LPN) states that the Hospital Physician called to inform V10 that resident had a ruptured eyeball and surgery to repair it went well. V17 (Hospital Trauma Resident Physician) stated, "Resident was either pushed or punched in the face resulting in a globe rupture of the eye. Resident needed surgery and is in stable condition. Social Services at the hospital reports that this is not the first time this has happened. Resident has had several altercations with his roommate in the past resulting in injury."

R3's progress notes dated 10/17/20 at 3:07pm states that R3 sustained multiple small superficial scratches to right side face and one scratch to left side cheek.

R1's nurse's notes written by V5 (Licensed Practical Nurse/LPN) on 10/17/20 at 11:40am (over 14 hours after the injury occurred) states that the Nurse Practitioner was called and notified about the bleeding and increased swelling to left eye and face. It was at this time that the nurse received orders to send R1 to the hospital. The ambulance transport staff then told the nurse that the expected time of arrival (ETA) for pick up would be 30-45 minutes. Facility's Incident Report states that time of incident was 8:50pm on 10/16/20 and R1's progress notes shows that the first time the Nurse Practitioner was notified of R1's injury was 10/17/20 at 4:25am and at 6:23am by V6 (LPN). This was about 7 hours after the injury. Also, R1 was not sent to the hospital until over 14 hours after the injury

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S9999	Continued From page 4 occurred. On 10/17/20, V20 (Hospital ER Physician) stated that R1 was sent to the hospital for a Level 2 Trauma. V17 (Hospital Trauma Resident Physician) wrote, "Resident was either pushed or punched in the face resulting in a globe rupture of the eye. Resident needed surgery and is in stable condition. Social Services at the hospital reports that this is not the first time this has happened. Resident has had several altercations with his roommate in the past resulting in injury." On 10/19/20 at 1:15pm, V3 (Nurse Consultant) was asked about all aggression incidents involving either R1 or R2. V3 returned with the document that shows that R2 initiated aggression incidents on 6/2/2019 and 12/24/2018, in addition to this incident that happened on 10/16/20 where R1 was seriously injured. There was no other incident documented in the past that involved R1. On 10/22/20 at 3:44pm, V1 (Administrator) stated that he completed the final investigation on the incident where R2 assaulted three other residents, and he was puzzled that not a single staff member witnessed the incident. V1 stated that from his investigation, R2 was probably upset because he was moved to another unit, and R2 became physically aggressive toward the residents. V1 explained that R2 went to attack each of the residents in their rooms. No records to show that any staff observed the incident to explain how R2 left his room and went to the room of the other resident and attacked them. The assigned nurse V14 (Licensed Practical Nurse/LPN) and V13 (the assigned Certified Nurse assistant/CNA) both stated that they did not know when the incident happened. Both V13 and V14 stated that none of the staff members on	S9999		

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S9999	Continued From page 5	S9999		

the floor witnessed the incidents with R2 versus R1 or R2 versus R3. On 10/20/20 at 11:40am, V14 stated that she was the assigned nurse for R1, but she went on lunch break and when she came back around 8:30pm on that day, the other nurse told her that R2 had attacked 3 residents, injuring two of them.

Facility's undated policy titled "Abuse Prevention Policy" states in part: Residents have the right to be free from abuse, neglect, and exploitation, misappropriation of property or mistreatment. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention.

Facility's policy dated 4/14, titled "Change in Condition Physician Notification Overview Guidelines" states in #3: Medical care emergency problems are communicated to attending physician and family immediately (generally within two hours or sooner).

2. On 10/19/20 at 1:15pm, V3 (Nurse Consultant) was asked about all aggression incidents involving either R1 or R2. V3 returned with the document that shows that R2 initiated aggression incidents on 6/2/2019 and 12/24/2018 against other residents, in addition to this incident that happened on 10/16/2020 where R1 was seriously injured.

R2's care plan dated 3/11/20 states that R2 is at risk for falls/accidents and R2 requires "continued monitoring when ambulating."

R2's MDS (Minimum Data Set) dated 10/14/20, section G, #D shows that R2 requires one person physical assistance to walk in the corridor on the unit (a score of 2). Also, #E shows that R2

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S9999	Continued From page 6 requires one person physical assistance to move on adjacent corridor on the same floor (score of 2). If staff followed what R2's MDS says regarding his functional status, R2 could not have gone from room to room to physically assault other residents without any staff knowing about it. Facility's policy on "Resident Rounds" dated 5/14 states under "Purpose:" To evaluate provision of resident care and to supervise and monitor staff adherence to the president's plan of care. #1 states: Rounds will be conducted at varying times and residents observed to assure care is provided according to assessed needs and changes in condition by all staff daily. (A)	S9999		