Illinois Department of Public Health

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 10/07/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID 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 Investigation of Facility Reported Incident of 9-18-21/IL138384	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240f) 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide supervision for an oriented, wheelchair-bound male resident who has the tendency to wander into female residents' room and exhibit inappropriate sexual gestures for one (R2) of 3 residents reviewed for supervision in the sample of 4 residents. This failure resulted in R2 propelling himself onto another resident floor via	S9999		

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elevator and entering R1's room where R2 wiggled R1's toes waking R1 out of deep sleep and scaring R1.

Findings include:

R2 is an oriented, deaf, mute wheelchair-bound 77-year-old male who requires supervision for his Activities of Daily Living (ADLs) per the quarterly Minimum Data Set (MDS) dated 7/1/21. R2 is assessed to have a Brief Interview for Mental Status (BIMS) of 10. R2's diagnoses include Schizophrenia, deaf, mute and Cerebrovascular Accident. R2 has resided in the facility since 3/28/14 per MDS.

On 10/5/21 at 11:55 AM, R1 stated the incident happened in the middle of the night between 2 AM to 4 AM. R1 stated she was sleeping in the first bed of a 3-bed room when she was awoken by R2. R2 was touching and wiggling her toes. R1 stated she grabbed R2's hands and yelled for help. R1 stated she saw R2's penis was out of his pants and she can describe it. R1 stated that she was pushing R2 out of her room as she was yelling. R1 did not know the names of staff or descriptions of them that came to the room. R1 stated R1 did not recall speaking to police but staff say she did talk to police for 20 minutes. R1 stated that R3 is her roommate and believes R3 told the nurse. R2 is from another floor.

On 10/5/21 at 12:07 PM, R2 was interviewed using an interpreter (V4/Outside Mental Health Program Professional for in-house programming) to communicate using sign language. V3 (Outside Mental Health Program Director) was also present. V4 stated R2 is oriented times person and place with periods of confusion, is deaf and mute and uses the sign language to

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communicate. V4 stated that R2 was signing that he went to R1's floor to have sex which is different from the original story. The original story was R2 was hearing voices and followed the voices to R1's room. V4 stated that R2 signed that R1 was dressed in bra and panties and screaming. Staff came and yelled at R2 to get off the floor and stay off floor. Both V3 and V4 stated that they have never heard or witnessed any inappropriate behavior from R2. Both stated that R2 does like to wander in his wheelchair, but it was never sexual. V4 stated that R2 likes to go to the 4th floor to visit a male, Polish friend and watch television with him. V4 stated that the friend's room is next to R1's room.

On 10/5/21 at 12:28 PM, V11 (Restorative Director) stated the residents are supposed to stay on their own floors and if they want to visit, it should be done in the patio during the day.

On 10/5/21 at 12:35 PM in R1's and R3's room, R3 stated she remembers the incident of 9/18/21. R3 stated she was awoken by R1 screaming and seeing R1 grab R2 saying "Get the nurse." R3 stated she reported it to the nurse and does not know the nurse's name.

On 10/5/21 at 1:35 PM, V5 (Certified Nurse Aide/CNA) stated she was working the 3 to 11 shift on the 5th floor when she saw R2 starting up with his episodes of wanting to fight, exhibiting sexual gestures, going in and out of the female rooms on the 5th floor. V5 stated she reported this behavior to V7 (5th floor nurse). V5 stated that V7 was redirecting R2 out of a female's room when he gestured to V7 that R2 wanted sex. V5 stated that V7 asked V5 if she saw R2 make the sexual gesture with his hands, but V5 did not see it because V5 had turned her back. V5 stated it

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S9999	Continued From page 4 was then shift change at 11 PM and V5 stated she headed down to the 4th floor to work a double. V5 stated she saw V6 (4th floor CNA) who told V5 that R2 was in R1's room and R1 was screaming rape. V5 stated she asked V6 if she informed the nurse. V5 stated it was 30 minutes later when R1 came to the nurses' station to report that R2 tried to rape her. V5 stated she questioned R1, "Was it rape?" V5 stated that R1 stated it was not rape but R2 was trying to persuade R1 to remove her clothes. V5 stated that R1 stated that R2 had shown his penis to R1. V5 stated that R2 is capable of transferring himself by standing and pivoting out of wheelchair. On 10/5/21 at 1:47 PM, V6 (CNA) stated she was arriving on the 4th floor for her 11 to 7 shift when she heard R1 screaming. V6 stated there was a nurse at the nurses' station but cannot identify her. V6 stated she was told the screams were from R1's room. V6 stated she saw R1 pushing R2 out of her room. R1 was screaming that R2 tried to remove her clothes as R1 was sleeping and wanted the police called. V6 stated that both nurses, V7 and V12 were informed of the incident between R1 and R2. On 10/6/21 at 8:26 AM, V8 (Licensed Practical Nurse/LPN) stated she worked the 11 PM to 7 AM shift on the 5th floor. V8 stated when she got to work, the off-going nurse V7 told V8 to keep an eye on R2 because R2 keeps going into female peers' rooms. V8 stated she was not told of the incident between R2 and R1 on the 4th floor. V8 stated that R2 likes to leave the floor and go to vending machines on 1st floor. V8 stated that this shift she watched R2 from the nurses' station. V8 stated that R2 can stand and pivot when transferring.	S9999		

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S9999	Continued From page 5 On 10/6/21 at 11 AM, V10 (CNA) stated she was starting her 11PM to 7AM shift on the 5th floor when she approached V7 (Nurse). V10 stated that V7 informed her to keep an eye on R2 who had been going in and out of female residents' rooms during the 3 PM to 11 PM shift. V10 stated as they were talking, the elevator door opened, and it was R2 getting off the elevator which surprised both of them. V10 stated she then put R2 in his bed. V10 stated as she was doing her rounds, V7 told V10 she had a phone call. V10 answered the phone and it was V6 (CNA). V6 told V10 to come to 4th floor. V6 told V10 that R2 was down on R1's floor in R1's room and R1 was screaming. V10 went back to 5th floor and told V7 (Nurse) about the incident on 4th floor with R2 and R1. V7 questioned why V6 didn't just tell V7 when V7 answered the phone. V10 stated that V7 is on vacation this week as to why V7 is not available. There was no documentation in either R1's or R2's clinical record about this alleged abuse. R2' care plan (10/1/21) documents R2 is an elopement risk. The approach is to monitor R2's location every shift, document the wandering behavior and attempted diversional interventions in behavioral log. This care plan was developed after the 9/18/21 incident. Prior to 10/1/21, there is no documented information on supervision or that R2 likes to wander. The facility's Supervision and Safety policy, which is lacking the facility's letterhead, documents that resident's safety and supervision are facility-wide priorities. The facility-wide approach to safety addresses the high-risk groups of wanderers, behaviors and aggression. Resident supervision	S9999		

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S9999	Continued From page 6 is core component to residents' safety. Socialization between residents will be encouraged daily in "Public" areas for increased supervision. Staff are to intervene immediately whenever an unfavorable event between residents, staff or visitors is noticed. Staff will make visual rounds on residents minimally every 2 hours and more often if necessary. (B)	S9999		