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 02/11/2021

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 Facility Reported Incident of 1-23-21/IL130577	S 000		
S9999	Final Observations Statement of Licensure Violation 300.1210b) 300.1210d)6) 300.3240a) 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 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 a) An owner, licensee, administrator, employee or	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide supervision for one (R1) of three residents reviewed for supervision. This failure resulted in R1, a highly delusional resident with no community survival skills, eloping from facility and was out in the community alone for 9 days with the weather bitterly cold. Findings include: On 2/10/21 at 12:30 PM in R1's room, R1 was sitting on edge of bed eating her lunch. R1 was asked about how she eloped from the facility and where she was for 9 days in the community. R1 responded she did not want to answer because she may want to elope again. R1 appeared highly delusional saying she has married many celebrities and has had babies by them. R1 stated her babies were taken away along with all her money, her cars, her businesses and her homes. R1 stated she does not feel safe, because there is someone who is trying to kill her. R1 stated she is currently going through a divorce and she is pregnant. As surveyor was leaving R1's room, V3 (Psychiatric Rehabilitation Service Director/PRSD) was at the doorway. R1 got up and walked slowly holding up pants that were loose and exposing her belly, saying to V3 that she is worried about her baby. V3 re-directed R1 back inside R1's room and reassured R1 that everything is okay. Record review documents R1 is an ambulatory	S9999		

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female who has been a resident of this facility since 6/14/11 per the face sheet and annual Minimum Data Set (MDS) dated 11/18/20. R1's diagnoses include Paranoid Schizophrenia, schizo-affective disorder, bipolar disorder, cognition-communication deficit, Diabetes Mellitus II and non-compliant with medications. R1 requires supervision of her activities of daily living. R1 is alert and orient times three with a Brief Interview for Mental Status (BIMS) score of 9. R1 is care planned (11/18/20 through 1/30/21) for her delusions of thinking the facility is trafficking women and children, the facility has taken her children, believes the staff use razors at night to take her babies from her, the behavior of refusing medications and care, displaying talking and laughing to self and being very agitated. R1 has also made 911 calls for non-emergency issues.

The outside entity providing psychosocial in-house programming documents in a 8/6/2020 assessment that R1 presents with grandiose and paranoid delusions, her experience of delusional belief system are severe and chronic in nature which impacts her willingness to be medication compliant, to engage in reality testing and the ability to build trusting relationships. R1 has trouble remembering information and events, but able to identify general information and current events. R1 presents with continued delusional thoughts about her environment.

On 2/10/21 at 11:10 AM and 1:15 PM, V1 (Administrator) stated he received a call from V12 (Licensed Practical Nurse/LPN) around 5:20 AM on 1/23/21 about a missing resident (R1). V1 stated he was told that R1 eloped. V1 stated he was told that the exit door did alarm but could not say how long it took for staff to respond to the

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alarm. V1 stated the camera monitor was viewed on Monday morning, 1/25/21. It showed R1 exiting out the north patio door and setting off the alarms. The time stamp was 11 PM but V1 stated the time stamp is not accurate and has been broken since he started working here.V1 stated he interviewed all staff but was only able to provide staff interviews for V9 (Certified Nursing Assistant/CNA) and V10 (CNA) and V13 (LPN), one of 2 nurses working the 3rd floor. There were no interviews from V11 (R1's assigned CNA), V12 (the other nurse assigned to 3rd floor), or V5 (Receptionist).

On 2/11/21 at 7:42 AM, V5 (Receptionist) stated she usually works 4:30 PM to 12 midnight but on 1/22/21 she worked until 3 AM. V5 stated she heard the exit alarm go off on the 1st floor around 2 AM and she called a code white. V5 stated that V12 (LPN), the other 3rd floor nurse, was down on 1st floor in reception area doing paperwork. V5 stated she called all nursing floors to ask about head counts and all nurses said the count was correct on floors. V5 stated she left the facility at 3 AM. V5 stated that the assistant administrator called her at home the next day and asked what happened. V5 stated, "No one responded to the alarm exit door because the resident count was okay." V5's time sheet validates V5's time in facility on 1/22-23/21.

On 2/10/21 at 1:55 PM, V2 (Assistant Administrator) stated there is a 24 hour receptionist. V2 stated she spoke with V5 (Receptionist) and V12 (LPN) about the elopement of R1. V2 stated V5 called a code white when she heard the exit alarm go off. V2 stated V5 called all nursing floors and spoke to nurses to get head count on each floor. Each nurse responded that the count on floor was

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correct and that no one missing. V2 stated she is not sure when staff left the facility to look for R1.

On 2/10/21 at 11:20 AM and again at 12:45 PM, V3 (PRSD) stated R1 is currently highly delusional believing she is pregnant and in the hospital, which is untrue. V3 stated it was not determined how R1 got out of the facility or where R1 was for the 9 days she was gone. V3 stated that R1 believes that someone is trying to kill her. V3 stated that it was the police that picked her up in the community and took her to the local hospital. R1 gave a fictitious name and stated she was pregnant (which is untrue). A former employee of the facility recognized R1 in the hospital and informed hospital staff that R1 is a resident in a nursing home. A hospital nurse called and informed the facility of R1's whereabouts.

Nurses note 2/2/21 documents local hospital calling and saying R1 is there. R1 had been in the community from 1/23/21 to 2/2/21, 9 days in the community.

On 2/10/21 at 1:25 PM and again at 2:30 PM, V6 (Program Director for an outside entity that provides in-house psychosocial programming services) stated R1 has been a resident of this facility since 2011. V6 stated that R1 has eloped 5 times since her admission. The last time prior to 1/23/21 was in 2016. V6 stated that it is R1's behavior to give a fictitious name when she goes to the hospital. V6 stated that R1 is an elopement risk and has no community survival skills due to her being non-compliant with medication and being very delusional.

On 2/10/21 at 1:28 PM, V7 (Outside Caseworker) stated V7 came to see R1 on 1/23/21 at 2:30 PM

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and discovered R1 was missing per a Certified Nurse Aide (CNA) on the floor. V7 stated she spoke with V2 (Assistant Administrator) who stated that the receptionist (V5) failed to announce the code white when the alarm went off and failed to have the outside area searched. V7 stated it was much later when V5 made the announcement for staff to do head count on the floors and the head count was okay per nurses.

Review of the facility's investigation into R1's elopement has a written statement by V10 (3rd floor CNA) who wrote V11 (assigned CNA to R1) discovered R1 missing at 4 AM when doing rounds. That is when the search was conducted for R1, which was two hours after the exit alarm was set off by R1.

The temperature for 1/23/21 in the early morning was in the upper teens to near 20 degrees Fahrenheit per V14's (Meteorologist) weather forecast.

R1's December 2020 and January 2021 Medication Administrator Record (MAR) documents R1 is non-compliant with her medications due to R1's refusal. The last time R1 took any medication including the psychoactive medication was 12/11/20.

R1's community survival assessments (11/18/20 and 1/25/21) document R1 is not capable of an unsupervised community pass due to her delusions. V3 (PRSD) completed both assessments.

The facility's policy Elopement Prevention Devices and Systems documents elopement alert exit door device will be inspected for proper working order. If the alarm at exit door is

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S9999	Continued From page 6 malfunctioning, maintenance will be notified, and a staff member placed at door to prevent unauthorized exits. Staff to begin facility and neighboring communities search immediately upon inability to locate a resident. (B)	S9999		