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 12/09/2021

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 Complaint Investigation 2188082/IL139808	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240g) 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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resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect

g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to follow its abuse policy and failed to protect a resident from potential further sexual abuse after R4 touched R1's breast and allowed R4 to continue residing on R1's floor after the incident. This affects one (R1) of 6 (R1, R2, R3, R4, R5 and R6) residents reviewed for abuse. These failures resulted in R1 experiencing increased anxiety, behavioral aggression and verbalizing expressions of self-harm.

Findings include:

The Facility's Abuse Prevention Program states under Purpose: The purpose of this policy and the Abuse Prevention Program is to describe the process for identification, assessment, and protection of residents from abuse, neglect, misappropriation of property and exploitation. Section V. Protection of Residents states: The facility will take steps to prevent mistreatment while the investigation is under way. Residents who allegedly mistreated another resident will be removed from contact with other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy,

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care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. Section VII. External Reporting of Potential Abuse states: 2. Five-day Final abuse Investigation Report. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health. The Public Health requirements for a final investigation report are detailed in paragraph five of the Internal Investigations section of this procedure.

R1 is a 42 year old female with medical diagnoses including Paranoid Schizophrenia, Bipolar Disorder and Anxiety Disorder. R1's Brief Interview of Mental Status (BIMS) score dated 9/2/21 was 13, indicating intact cognition.

On 10/10/21 V10 (Wound Care Nurse/Floor Nurse) documented on R4's Progress Note that it was communicated to her (V10) that resident (R4) was witnessed exiting from peer's (R1's) room, peer (R1) states: "He touched my breast." Staff redirected resident (R4) to his room, social service communicated to resident (R4) not to enter peer's room, education, and therapeutic communication was offered to resident.

Final Report dated 10/15/21 documented: As per charge nurse (V9), R1 reported to her that R4 touched her breast. Charge nurse interviewed R1 to ascertain her level of comfortability. R1 stated that she is OK and that she feels safe in the facility, R4 did it one time."

On 10/15/21 V8 (Psychiatric Rehab Services Coordinator) documented on R1's Progress

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Notes that she (V8) was informed about the allegation by R1 that she (R1) was touched inappropriately by another peer. R4's Progress Notes with the same date reads that she (V8) educated R4 on expressing his feeling and using his coping skills when he feels anxious and increased sexual excitement.

Per facility census and R1's notes, R1 stayed in the same room on the same floor as R4 from 10/10/21 to 10/15/21. R1 was moved to a different floor on 10/15/21.

On 10/27/21 V11 (Psychiatric Rehab Services Coordinator) documented on R1's Progress Notes that R1 expressed that she (R1) was having thoughts of self-harm and that R1 appeared in a high state of anxiety.

On 10/31/21 V5 (LPN) documented that R1 came out of R1's room yelling "He found me, he found me." V5 stated, "That's why I moved R1 off that floor."

On 11/23/21 at 11:20 AM R1 was observed alert and able to express her thoughts well. R1 stated that many people came inside her room and touched her inappropriately. When asked if R1 could remember who came inside her room, R1 stated that R4 came to her room and showed her his penis. R1 said it happened in the past but cannot remember exact dates. R1 then said that R4 was staying on (X) floor. R1 stated R1 wants to leave the facility because R1 does not feel safe.

During interview V5 (LPN) stated that on 10/31/21 she was the nurse taking care of R1. V5 stated that day R1 came out of her room yelling, "He found me and raped me! He raped me!" I (V5)

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S9999	Continued From page 4 called the social worker, who was V7 (Social Service Director). V7 came and spoke with R1. I called the Administrator (V6/Past Administrator) immediately and V6 said that R1 needed to be transferred to the hospital. After that, R1 called 911 and the police came and spoke with R1. V5 further said, "This was the first time I encountered R1 having this behavior and I worked regularly with R1." At 11:54 AM V7 (Social Service Director) stated that R1 was transferred to the hospital via Petition for Involuntary/Judicial Admission. At 12:17 PM V9 (Regional Consultant/Acting Administrator) stated that this happened during V6's (Past Administrator) time so he has limited information. (V9) stated V9 was not aware that V5 (LPN) stated on 10/31/21 R1 said, "He found me and raped me! He raped me!" V9 was asked about facility report to State Agency on the incident that happened on 10/31/21. V9 stated that there is no record of report dated 10/15/21 and 10/31/21. V9 stated the only incident that was reported to State Agency was on 10/10/21. V9 then provided a Final Report dated 10/15/21 but not the Preliminary Report that it was sent to State Agency. According to V9 the facility cannot find the preliminary report with the date sent to the State Agency. Request for Preliminary Report and details of the investigation was requested on 11/23/21 at 12:17 PM, 11/24/21 9:36 AM and 11:05 AM. V9 stated the only document they can find was the Final Report dated 10/15/21 without details of the investigation. On 11/24/21 at 9:57 AM. V8 (Psychiatric Rehab Services Coordinator) stated that R1 has mental illness diagnoses which include Schizophrenia, Bipolar and Anxiety Disorder. V8 stated V8 was aware of the incident of 10/10/21 regarding R4 touching R1's breast. V8 stated that as a Social	S9999		

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Worker, V8 felt it was natural for R1 to be uncomfortable and afraid because of the incident that happened on 10/10/21. V8 stated, "Yes, I agree that R1 would want to feel safe after the incident that happened between R1 and R4. I don't know what took them so long time to transfer R1 to another floor. But I agree she should have been transferred immediately. I do not know why R4 was not transferred to another floor. Any female person would feel uncomfortable, afraid and would want to feel safe if someone touched her without her consent." V8 further stated that she was aware that R1 verbalized expressions of self-harm and R1's increased anxiety and behavioral aggression manifested after the 10/10/21 incident.

On 11/24/21 at 11:05 AM. V9 (Regional Consultant/Acting Administrator) stated that upon further inquiry it was found out that R1 and R4 resided on the same floor from the time of the incident 10/10/21 until 10/15/21. Although R4 went to the hospital on 10/11/21, R4 came back the same day. V9 stated except on the hours R4 went to the hospital, R1 and R4 were on the same floor. V9 also stated that he understands that any female resident would feel afraid and anxious if touched by a male resident without consent. V9 stated, "I understand the concerns related to abuse, reporting and investigation abuse. See what I inherited {this situation}?"

R1's Petition for Involuntary/Judicial Admission dated 10/31/21 documents: R1's diagnoses include Paranoid Schizophrenia and Bipolar Disorder. R1 has shown an increase in anxiousness and believing everyone wants to harm her. Currently not responding to staff directives or as needed medication. R1 is currently pacing the unit. R1 is in need of

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hospitalization.

R1's care plan documents that R1 is at risk for abuse and neglect based on her diagnoses. The goal for R1 is to be treated with respect, dignity and reside in the facility free of mistreatment. Facility intervention is to assure that R1 is in a safe and secure environment.

R4 is a 34 year old male with medical diagnoses including Schizophrenia and Bilateral Hearing Loss. R4's BIMS score date 11/26/21 is 13 which indicates intact cognition.

On 11/23/21 at 11:15 AM R4 was observed in his room sitting on a chair. R4 was alert but was signaled that he cannot hear. Surveyor wrote R4's name on a piece of paper, which R4 acknowledged. Surveyor wrote R1's name; R4 did not respond. Surveyor wrote R1's floor number on the paper; R4 did not respond. Surveyor wrote the words, "KNOW HER?" on the piece of paper. R4 continued to not respond.

On 12/7/21 at 11:10 AM during interview, V12 (LPN) stated that R4 cannot communicate well because of hearing problems. V12 stated staff from Social Services communicate with R4 through sign language, and R4 also knows how to read lips. V12 also stated that R4 is ambulatory and uses the elevator to transfer to other floors. V12 further stated that R4 has behavioral issues of touching female residents and staff. At 11:21 AM R5 stated that R4 was very aggressive towards female residents. R5 said, "R4 grabs "t**s" and "b***s" of female residents. R4 does it in the hallway or at the Nurse's Station and at times goes inside resident's rooms. R5 stated R6 used to be here in R5's room and R4 followed R6 inside the room. R4 grabbed R6's breast and

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behind. Because of that incident R6 was transferred to another room. At 11:35 AM R6 confirmed that R4 inappropriately grabbed her in 2 separate incidents. R6 stated that first R4 grabbed her breast; second, R4 grabbed her behind. R6 said, "Yes, I was in the room with R5 before. And R4 touched me inappropriately on the breast and on my behind. It happened in two separate incidents, but I cannot remember the exact dates. It was months ago. After I was transferred to this room, there have been no more incidents with R4."

On 12/7/21 at 12:15 PM V9 (Regional Consultant/Acting Administrator) stated that the incident related to R1 and R4 on 10/10/21 does have a preliminary report but does not have a time stamped that it was sent to the State Agency. V9 stated the final report has a time stamp dated 10/15/21 but does not have the details of the investigation. V9 stated that based on the preliminary report, R4 touched R1's breast. V9 also stated that for the notes dated 10/15/21, V9 thinks the writer (Social Services) was referring to the incident dated 10/10/21 when she wrote those notes. V9 stated the incident dated 10/31/21 was not reported because according to V5 (LPN) R1 was not making any sense and that due to R1's medical diagnosis related to her mental status, what R1 was saying was not reliable. V9 said, "If I am in that situation, I will ask R1 who raped her, when did it happen, and so on and so forth. Then R1 called the police, and the incident number was given to us, but we don't have hard copy. I think the police report number was written on the progress notes. I did not know that R4 has other sexual inappropriate behavior incidents beside what happened to R1. I don't know about R4's incidents on progress notes dated 8/28/21 and 8/29/21 which document R4

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S9999	Continued From page 8 having inappropriate sexual behavior directed towards facility staff and peers. But if the behaviors were directed towards facility staff, we do not report it to the State Agency since it does not involve residents as victims." R4's Progress Notes documentation multiple incidents related to R4's inappropriate sexual behavior. On 6/17/21 V13 (Registered Nurse/RN) documented: R4 was seen going into female peer's room. On 7/22/21 V7 (Social Service Director) documented: R4 left the shower area without putting on his clothes. On 8/22/21 V15 (LPN) documented: R4 was sexually inappropriate with peer. On 8/27/21 V16 (LPN) documented: R4 was observed going in female resident's room. On 8/28/21 V10 (Wound Care Nurse/Floor Nurse) documented: R4 was sexually inappropriate towards staff. Shortly after, resident attempted to be sexually inappropriate toward peer. On 8/29/21 V10 (Wound Care Nurse/Floor Nurse) documented: R4 again attempting to be sexually inappropriate towards peer. On 10/2/21 V11 (Psychiatric Rehab Services Coordinator) documented: Social Services was made aware that a peer expressed concerns to nursing regarding R4 interaction with her. R4 was educated on maintaining awareness of personal boundaries and the personal space of his peers. On 10/10/21 V10 (Wound Care Nurse/Floor Nurse) documented: It was communicated to her (V10) that R4 was witnessed exiting from (R1's) peer's room. Peer (R1) states: "He touched my breast." Multiple notes by V17 (Minimum Data Set/MDS/Care Plan Coordinator) document that during look back period R4 has displayed symptoms of being sexually inappropriate.	S9999		

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S9999	Continued From page 9 R4's care plan documents that R4 exhibits sexually inappropriate behavior symptoms related to severe mental illness. Behavior symptoms are manifested by: Making crude, sexually-oriented, profane or suggestive remarks, physical touching, grabbing, sexual behavior in public place. V9's (Regional Consultant/Acting Administrator) email dated 12/8/21 documents that there was no reportable or investigation for the month of August 2021 related to multiple incidents documented on R4's progress notes. On 12/9/21 at 10:35 AM V18 (Psychiatrist) stated R1 and R4 are his patients. R1 has baseline of paranoid behavior because of her mental diagnosis. R1 expresses leaving the facility but in his professional opinion, R1 will not survive because of many factors including unable to take medications and her mental state. V18 stated R4 has sexual inappropriate behaviors. When V18 was informed that R1's notes documented that she (R1) had thoughts to harm herself, V18 stated, "I was not informed about previous incidents with R4, and I was not aware that R1 had thoughts of harming herself. The facility should update me of all situations. Any female person with mental illness or medical diagnosis like R1 who experiences an event such as a male person going inside her room, whether it is true or not that she was being touched by a male person without her consent, that stressor will result in a very traumatic experience, nightmares, feeling uncomfortable and unsafe. The person will develop fear to a specific race or will fear that something or someone is out to get them and will have aggressive behaviors." When asked if the allegation by R1 regarding R4 would result in a need to separate R1 from R4 or vice-versa, V18 stated, "Definitely yes. They (R1 and R4) should	S9999		

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S9999	Continued From page 10 not cross paths with each other. The Facility needs to think about alternatives, like transferring residents to a safe environment. The Facility should be on top of it." R5 is a 62 year old female with medical diagnoses including COPD (Chronic Obstructive Pulmonary Disease). R5's BIMS score dated 9/15/21 was 15, indicating intact cognition. R6 is a 63 year old female with a medical diagnosis of Major Depressive Disorder. R6's BIMS score dated 11/4/21 was 15, indicating intact cognition. (B)	S9999		