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 10/27/2023

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 FRI of 9/19/2023/IL165097 & FRI of 9/27/2023/IL165388	S 000		
S9999	Final Observations Statement of Licesure Violations 300.610a) 300.1210b) 300.1210d)6 300.3240a) 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 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.

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 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 interview and record review, the facility failed to prevent resident to resident abuse and resident to employee. This failure affected two (R2, R1) residents in a sample of three residents reviewed for abuse. This failure resulted in (R4) with known aggressions striking (R2) in the face causing inury. This failure resulted in R1 being verbally and mentally abused by V3(former cook).

Findings include:

1. R2 and R4 are no longer in the facility and were reviewed as closed records. R2's electronic medical record documents that R2 was discharged to the hospital on 10/05/2023 and has

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not returned back to the facility. R4's electronic medical record documents that R4 was discharged from the facility on 10/02/2023 and has not returned back to the facility.

On 10/24/2023 at 12:57PM, V4 (Registered Nurse) stated she started her shift at 11pm on 09/27/2023, the date of the incident between R2 and R4. V4 stated another resident wandered into R4's room and R4 was upset about that. V4 stated that R2 informed her that R2 wanted some water from the dispenser in the hallway on the 4th floor, which was close to R4's room at the time. V4 stated that R2 usually spills water everywhere when R2 tries to get water by himself so V4 went to assist R2. V4 stated that she and R2 were located at the water dispenser and R4 came out of his room and reached over V4 and punched R2 in the face. V4 stated that R4 did not say any words and believed that R4 was responding to internal stimuli. V4 separated R2 and R4 and another staff member assisted R4 to his room. V4 stated she gave R2 first aid for a nose bleed and there was a small amount of blood and took 5 minutes to stop the bleeding. V4 stated that upon her assessment, R2 did not have any nasal swelling and R2's nose did not appear broken. V4 stated she called her supervisor and called 911 to make a report. V4 stated the police came to the facility in less than 10 minutes. The ambulance also arrived and R2 went out to the local hospital to be evaluated and R2 returned to the facility later that night. V4 stated R4 also went out to the hospital. V4 stated she also called the medical director and got the order to send R4 out to the hospital to have a psychiatric evaluation. V4 stated that R4 has a history of being physically aggressive.

On 10/26/2023 at 9:27am, V1 (Administrator)

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stated he is the abuse coordinator, and a staff member called him and informed him that R4 was aggressive towards R2. V1 stated he informed the staff member to separate R2 and R4 and call the doctor to petition to get R4 out to have a psychiatric evaluation. V1 stated R2 was also sent to the local hospital to be medically evaluated. V1 stated R4 has a history of violence towards peers and staff. V1 stated that it was a danger to residents for R4 to continue to be in the facility due to R4's history of physically aggression.
V1 stated he witnessed via video the physical abuse that took place between R2 and R4. V1 stated that upon viewing the video himself, he saw that R4 hit R2, unprovoked.

R2s' Facesheet documents that R2 has diagnoses not limited to: Schizoaffective disorder, hypothyroidism, epilepsy, alcohol abuse, depression, insomnia, borderline personality disorder, and anxiety disorder.

R2's Minimum Data Set/MDS dated 09/27/2023, R2 has a BIMS/Brief Interview for Mental Status of 05, indicating that R2 is cognitively impaired. R2 requires independence with ADL/Activities of Daily Living care. R2 is continent of bowel and bladder, and ambulates via walking. Care plan dated 10/12/2023 documents that R2 is care planned for psychotropic medication, alterations in comfort, risk for metabolic dysfunction, risk for injury, self-care deficit, risk for abuse, mood and anxiety disorder.

R2s' care plan states "R2 will be treated with respect, dignity, and reside in the facility free of mistreatment (i.e., abuse/neglect) (on-going)."

R4s' Facesheet documents that R4 has

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diagnoses not limited to: cognitive communication deficit, schizoaffective disorder, mood disorder with depressive features, paranoid schizophrenia, unspecified psychosis, insomnia, violent behavior, and epilepsy.

R4's MDS dated 06/28/2023 documents that R4 has a BIMS of 06, indicating that R4 is cognitively impaired. R4 requires supervision and set-up and one-person physical assist with ADL care. R4 ambulates via walker and is continent of bowel and has an indwelling urinary catheter for bladder incontinence. R4s' care plan dated 07/26/2023 documents that R4 is care planned for physical aggression, risk for injury, risk for altered cardiac function, psychotropic medications, risk for falls, threatening and violent behaviors, severe mental illness, and risk for abuse.

R4s' progress notes dated 09/27/2023 reviewed and documents that R4 was physically aggressive towards his peer (identified as R2) and R4 was transferred to a hospital for psychiatric evaluation.

Progress notes written by V4 (RN) on 09/27/2023 documents in part, "At 01:25, R4 was agitated and became physically aggressive towards peer (R2) punching R2 in the face while R2 was getting water from the water dispenser. Residents were separated. MD, police and administrator notified. Order given to send R4 out to hospital for psychiatric evaluation. ETA for ambulance is between 7-8am. Police report received from Officers, Beat 1522, RD#JG440-661."

R4s' care plan states "R4 has a history of displaying physical aggression towards his peers. The history includes: threatening behavior, verbal or physical aggression. R4 has been given an IVD (involuntary discharge) due to R4's recent

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aggressive behavior towards a peer."

Facility Reported Incident dated 09/27/2023 documents in part that V4 (RN) witnessed R4 walk up to R2 and hit R2 in the face for no known reason. R2 sustained a bloody nose as a result of R4 hitting R2 in the face. Police report dated 09/27/2023 documents an incident of battery with report # JG440-661.

Facility policy, dated 2011, titled "Abuse Prevention Program Facility Policy" documents in part, "This facility affirms the right of our residents to be free from abuse .....abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish."

2. On 10/24/2023 at 1:47pm, R1 said on that day (09/18/2023) during dinner, she did not get her dinner tray and she informed staff (No name provided) about it. R1 said and she was told it was better for her to go to the kitchen to get her food, so that she can tell the kitchen staff what she wanted. R1 said she went and got V9(Psychiatric Rehabilitation Services Coordinator -PRSC) to take her to the kitchen. R1 said they found V3(Former Cook) in the kitchen and V9 asked her for R1's dinner tray. R1 stated V3 said she would not get R1 any food tray, and if it was up to V3, she would feed R1 cat food than give R1 a sandwich R1. R1 said V9 asked V3 what she (V3) had said, and V3 repeated that she would feed R1 cat food if it was up to her, then give R1 a sandwich. R1 said she and V9 left the kitchen without saying anything, and R1 said she felt hurt, disrespected, and she "felt like a nobody", and felt like she was being treated like a child. R1 said she would not eat anything from the kitchen if V3 was still in the kitchen because she

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was scared V3 might feed her some bad food. R1 said she did not eat that night because she feared something bad might be put in her food. R1 said went and got a bag of potatoes to eat for dinner. R1 said she slept very upset, and she was hungry.

On 10/25/2023 at 10:53am V9(Psychiatric Rehabilitation Services Coordinator -PRSC) said stated 09/18/2023, she took R1 to the kitchen to get a sandwich after R1 said she was brought the wrong food than what she had ordered. V9 said V3(Former cook) gave R1 a regular sandwich, but R1 said she wanted a sub sandwich. V9 said V3 got irritated by R1 and instead of V3 deescalating the issue, she escalated the situation by telling R1 that she, V3 would rather feed R1 cat food than give R1 a sub sandwich. V9 said at that point, she asked R1 to go back to the unit and escorted R1 back to the floor to prevent further escalation of the situation. V9 said she went back to the kitchen to speak to V3, and informed V3 that she(V9) was going to call V1(administrator) to inform his about the verbal exchange directed to R1 by V3. V9 said what V3 told R1 is a form of abuse (Verbal& mental) and staff should not tell residents such statements and should be deescalating the situation instead if escalating it.

On 10/24/2023 at 1:10pm, (Director of Nursing-DON), said she was the DON when R1 was verbally abused by V3. V2 said V3 telling R1 that she(V3) would rather serve R1 cat food than make her a sandwich is definitely verbal and emotional abuse, and it could have had so many ramifications for R1, such as R1 refusing/stopping to eat from the kitchen for fear of being served cat food.

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S9999	Continued From page 7 On 10/26/2023 at 11:48am V15(Social Services Director) said R1 come to her office on 09/19/2023 and told V15 that the evening before, V3 had spoken to her(R1) inappropriately. V15 said V9(PRSD) told her that she had witnessed the verbal abuse by V3 towards R1. V15 said what V3 told R1 was verbal abuse and mental and can affect a resident's dignity, and staff should never engage with a resident inappropriately, and staff should deescalate the situation if a resident is agitated. On 10/24/2023 at 1:22 V1(Administrator)said more than likely the verbal abuse happened because a staff member (V9- Psychiatric Rehabilitation Services Coordinator-PRSC), was present when the abuse happened, and V9 said she heard V3 say to R1 that V3 told her she would rather serve her(R1) cat food than make her sandwich. V1 said after the allegation happened, R1 come to V1's office the following day and told V1 him it. Social Service Note dated 9/19/2023 10:46 Documents: -R1 met with V5 and reported she was verbally threatened by V3 on 9/18/2023 around 6pm. Review of V3's HR record with V8 document: -12/08/22- V3 was suspended pending investigation for verbal and emotional abuse to residents (No name/s of the residents) - 9/19/2023, V3 was suspended pending investigation of alleged abuse to R1 Facility Reported Incident Report (FRI) dated 9/19/2023 documents: - R1 told V3 that her food order was wrong, and V3 told R1 that she(V3) would rather serve R1 cat food than make R1 a sandwich.	S9999		

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S9999	Continued From page 8 -Facility has evidence to support allegation made by R1. Abuse Prevention Program, Facility Policy Dated 2011 documents: -This facility affirms the right of our residents to be free from abuse, neglect. -The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of the mistreatment, neglect, or abuse of our residents. -Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents of families or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but not limited to, threats of harm, saying things to frighten a resident. -Mental abuse includes but not limited to, humiliation, harassment, threats of punishment or deprivation. (B)	S9999		