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 12/23/2024

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 FRI of 9/30/2024/IL182362	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6 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 resident to meet the total nursing and personal	S9999		

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care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

These Requirements were NOT MET as evidenced by:

Based on interview and record review, the facility failed to protect one resident (R1) out of 9 from physical abuse. This failure affected R1 who was pushed in the elevator by R8. As a result, R1 had an unwitnessed fall, R1 was sent to a local hospital. R1 sustained a left lateral tibial plateau fracture approximately 1mm (One millimeter) depression and small joint effusion.

Findings include:

R1's medical record Admission record showed documentation that R1 was originally admitted to the facility on 08/01/2014 with latest recorded admission date of 12/02/17. Listed diagnosis includes but not limited to Displaced fracture of lateral condyle of the left tibia, subsequent encounter to closed fracture with routine healing, type 2 diabetes mellitus without complications,

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muscle weakness (Generalized), paranoid schizophrenia, depression, unspecified fracture of shaft of left fibula initial encounter for closed fracture.

R8's medical record Admission Record showed that R8 original admission date as 08/22/2023 and latest admission date 11/02/2023 with diagnosis list that includes but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. Aphasia, weakness, unspecified abnormal of gait and mobility, furuncle of neck, restlessness, and agitation.

On 12/16/24 at 11:45am R1 noted on the 1st floor of the facility ambulating around with a sit to stand roller walker. R1 was able to communicate in English as a second language. R1 was able to remember about what happened on 09/30/24 stating that one man pushed R1. R1 stated that "I was next to the wall in the elevator (indicating that there was no other space to move in the elevator)." R1 stated the man pushed R1 to the floor (Fall to the floor) and broke R1 leg.

According to the facility Preliminary Incident Investigation Report dated 09/30/24. V1 (Administrator) documented that he (V1) was notified by a facility nurse that (R8) was physically aggressive towards (R1) in the elevator on the 4th floor. Both residents were checked for injuries. R1 was noted to have pain in the left knee. R1 was sent to the (hospital) for evaluation. V1 documented that R8 forcefully rolled into the elevator hitting R1 in the legs causing R1 to fall. R8 was interviewed and R8 stated that R1 would not let (R8) into the elevator and hit (R8). R8 stated R1 fell on (R1)'s own. V1 documented that (V10 Nurse) was interviewed and stated she did

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not see the altercation but heard yelling. V10 walked to the elevator and saw R1 on the ground complaining of knee pain. V1 documented that both resident (R1 and R8) files (medical Record) were reviewed. R1 was noted to have history of verbal aggression and R8 was noted to have history of verbal and physical aggressiveness. The report documentation showed that the local law enforcement (police) and both residents' physician was notified. Recording the incident as a simple battery.

R1's hospital record dated 09/30/24 documented that R1's reason for visit "patient (R1) here for L (left) knee pain s/p (status post) fall from wheelchair in the elevator 2 hrs PTA (Prior to Arrival) per patient (R1)." R1's hospital record presented showed documentation that CT (Computer Tomography) left knee without contrast showed that R1 had lateral tibial plateau fracture approximately 1mm (One millimeter) depression and small joint effusion.

On 12/17/24 at 10:00 am, when the surveyor asked about the conclusion of the incident of the incident of 09/30/24 and if this incident can be a form of abuse. V1 (Administrator) stated that "yes, it is an abuse, I will consider that to be abuse." V1 stated that due to R8's history of being verbally and physically aggressive towards peers R8 was sent to the hospital for psych-eval and has not returned to the facility.

On 12/17/24 at 10:08 am V2 DON (Director of Nurse's) who was present at this time stated "it is a form of abuse because R8 pushed R1."

On 12/17/24 at 12:38 pm, V10 (Licensed Practical Nurse) who identified self as the nurse in charge on the 4th floor at the time of incident

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on 09/30/24. V10 stated that "Yes, I was passing meds (Medicines) on the 4th floor when I heard some noise between residents on the 4th floor elevator. I (V10) went to see what was happening. I (V10) saw (R1) on the floor in the elevator lying down on the floor inside the elevator. (R8) was in-between the entrance of the elevator, the elevator could not close. I (V10) asked what happened and R1 said R8 pushed her. So, I called the front desk (receptionist) to call social services and V1 (Administrator). After that I (V10) assessed R1 who was having lots of pain to the legs. I (V10) could not remember which leg, but I think is the left leg, I called 911 (emergency number). I (V10) called the guardian and R1 was sent to the hospital, R8 was also sent to the (local hospital) for psych-evaluation." The surveyor asked V10 in your professional opinion can this incident on 09/30/24 be considered a form of abuse, V10 stated "Yes".

On 12/18/24 at 12:07pm, V3 NP (Nurse Practitioner) stated that R1 had a fracture of the tibia. V3 stated in part that after the unwitnessed fall (R1) was complaining of left knee pain, so V3 sent R1 out (to the hospital). When asked whether in V3 medical professional opinion if R1's fracture occur due to the fall. V3 stated "I do believe so".

R1's falls/accident care plan initiated on 10/13/2028 and revision date 07/12/2022 showed that R1 is at high risk for fall. Goal documented that R1 will not sustain injury throughout the review date. Initiated date 10/13/2018, revision date 11/21/2024 and target date 02/05/2025. R1's MDS (Minimum Data Set) dated 11/07/2024 showed that R1 has a BIMS (Brief Interview for Mental Status) Score of 04.

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S9999	Continued From page 5 R8's plan of care initiated 03/26/2024 with revision date 04/01/2024 showed a focus documentation that R8 has history of being physically aggressive toward others when angry and due to poor impulse control. Goal is that R8 will not harm self or others through the review date initiated 04/01/2024, revised date 06/20/2024 and target date 12/29/24. The interventions listed includes but not limited to assisting verbalization of source of agitation and seeking out of staff member when agitated. R8's MDS (Minimum Data Set) dated 09/23/2024 showed that R8 has a BIMS (Brief Interview for Mental Status) Score of 11. The facility Abuse Prevention Program policy presented documented in part that the facility affirms the right of our residents to be free from abuse. this facility therefore prohibits mistreatment, neglect, or abuse of its residents. The facility is committed to protecting our residents from abuse by anyone including, but not limited to another resident. The policy documented in part that abuse means/ includes any physical injury or mental injury. Abuse is willful infliction of injury. Physical abuse is infliction of injury on a resident that occurs other than by accidental means. (B)	S9999		