

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002067	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER AUSTIN OASIS, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaint Survey: 2580717/IL185244	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3210t) 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 care needs of the resident.	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/26/25

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S9999	Continued From page 1 Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These Requirements were NOT MET as evidenced by: Based on observation, interview and record review, facility failed to protect a resident from physical abuse. This failure affected one resident (R1) of 4 residents reviewed for physical abuse. This failure resulted in R2 physically attacking R1, resulting in R1 bleeding from an abrasion R1 sustained under the left eye and R1 being transferred to the hospital for evaluation and treatment. Findings include: Facility's Final Investigation Report (dated 02/03/2025) documents in part: On 01/27/2025, the facility administrator was notified by a facility nurse that resident R2 was physically aggressive towards resident R1. R1 was noted to have an abrasion under her left eye for which care was provided by her assigned nurse. Both residents' representatives were notified of the reported incident along with the resident's physician and the police. R2 refused to be interviewed and left the facility against medical advice. R1 was interviewed and stated that R2 has become verbally and physically aggressive towards her for no reason. R1 stated that R2 struck and grabbed her prior to pushing her out of their shared room. R1 was sent to the hospital for safety precautions.	S9999			

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S9999	Continued From page 2 Abuse Prevention Program Facility Policy (dated 2011) documents in part. The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property corporal punishment and involuntary seclusion. This will be done by identifying occurrences and patterns of potential mistreatment, immediately protecting residents involved in identifying reports of possible abuse. R1's Face Sheet documents resident is a 70-year-old with diagnoses including but not limited to: Chronic obstructive pulmonary disease with (acute) exacerbation, heart failure, hypotension, insomnia, shortness of breath, abdominal distension (gaseous). Minimum Data Set Section (MDS) section C (dated Jan. 1, 2025) documents that R1 has a Interview for Mental Status (BIMS) score of 14, indicating that R1's cognition is intact. Care plan (dated 12/18/2024) documents that R1 is at risk for alteration in comfort related to advanced disease process, chronic physical disability. R2's Face Sheet documents resident is a 33-year-old with diagnoses including but not limited to: schizoaffective disorder, bipolar type, unspecified psychosis not due to a substance or known physiological condition, anemia, bipolar disorder, altered mental status. Minimum Data Set Section C (dated Dec. 12, 2024) documents that R2's Brief Interview for Mental Status (BIMS) score is 14, indicating that R2's cognition is intact. Care plan (dated 01/14/2025) documents that R2 displays behavioral symptoms related to: Severe mental illness, poor and/or ineffective coping skills. These behavioral symptoms are	S9999			

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S9999	Continued From page 3 manifested by verbal abuse/aggression, and disturbed sense of entitlement. On 02/06/2025, at 10:13 AM, V1 (administrator) stated, "On 01/27/2025, it was reported to me that there was a loud commotion coming from R1 and R2's room. R1 and R2 were roommates at the time. V3 (registered nurse) went down the hallway to see what was going on. He explained to me that he saw R2 throw/push R1 from their bedroom into the hallway. V3 immediately intervened and escorted R1 to the nurse's station. V3 called the nursing supervisor and the nursing supervisor called me. We called the family; the physician and we called the police. The nursing supervisor went to speak to R2. R2 was informed that the police were called. R2 was notified that she would be petitioned and sent out to the hospital. R2 said that she refused to be sent to the hospital. R2 signed herself out against medical advice and left the facility. R1 said that R2 attacked R1 for no reason. V3 said that it appeared like R2 was going through some psychosis issues because R2 was acting bizarre and making weird statements that did not make sense. This could be the possible reason why she attacked R1. R1 had an abrasion under her eye. R1 said that R2 hit her, grabbed her and pushed her out of the room. R1 was kept safe away from R2. R1 was sent out to the hospital because she had an abrasion under her eye, and we were not sure if R2 hit R1 on the head. R1 is frail and R2 was of bigger frame, so that was an advantage over R1." On 02/06/2025, at 11:31 AM, during an interview with R1, surveyor observed an abrasion under R1's left eye, which appeared to be healing. R1 stated, "On 01/27/2025, R2 was my roommate at the time. I was sitting on my bed, watching tv and	S9999		

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S9999	Continued From page 4 doing puzzles. R2 said to me, "B**** it's my room get out." Then R2 started attacking me. R2 started hitting me on my face and on my head and pulled my hair. R2 was beating me, and I fell to the floor. Then R2 grabbed me by my hair and called me names. R2 pulled me into the hallway by my hair. R2 went back into the room and slammed the door. The nurse came and asked me what happened. The nurse went into the room to talk to R2. The nurse gave me gauze to wipe my face and the nurse took me to the nursing station and called the social worker. My family, the physician and the police were notified. I was sent to the hospital because I was bleeding. I had a cut under my eye. I was examined in the hospital, and I received a tetanus shot just in case due to the scratches. R2 attacked me for absolutely no reason. I never provoked R2 in any way. R2 and I never had any issues in the past prior to the physical attack. I want to press charges against R2 but she left before the police came and now they cannot find her." On 02/06/2025, at 2:39 PM, V3 (registered nurse) stated, "On 01/27/2025, R2 came and told me that she wanted to change rooms because she did not like her roommate. When I asked R2 what her issue was with her roommate, R2 said that she did not have to explain herself to me. I told her that social services handled room changes and since it was still relatively early, she can still talk to social services. R2 did not want to do that and said to me, "What if I go in there and beat the woman up." I told her that she should not do that because then I would have to call the police. She left to go to her room, and she came back a short while later and called her mom. R2 started to complain to her mom that she was mad at her roommate and that she was going to do something to her roommate. R2 slammed the	S9999			

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S9999	Continued From page 5 phone and went to her room and started knocking things down to the floor on her way to her room. I figured that she was going to do something to her roommate because R2 was upset. I got on the phone with social services to let them know that there is an incident possibly brewing and that the social worker needed to come up. In the middle of that phone call, I heard yelling and commotion in R1 and R2's room. I went to the room, and I saw R2 tossing R1 out of the room. R2 tossed R1 into the hallway with a lot of force, holding R1 by her pants. I separated R1 and R2 by getting in between them. Social services came up also and I took R1 by the nursing station. I tended to R1's laceration under her left eye because it was bleeding. R2 left against medical advice from the facility before the police got there. R1 was sent to the hospital for evaluation for the laceration under her eye." R1's Progress Note (dated 01/27/2025) documents, "While on the phone with social services at start of this incident. Writer heard yelling coming from the residents' room. Writer went to the room and saw R1's roommate holding her by her hair and back of her pants tossing her out into the hallway. Writer stood between the two residents to prevent further assault until social services arrived. Residents separated; vitals taken. R1 stated she did not hit her head. A small 1 centimeter laceration was noted under the left eye. Writer dressed the wound with gauze. There was minor bleeding. R1 was medicated with Tylenol for pain. R1's Progress Note (dated 01/28/2025) documents, "Received report from nurse at community hospital. CT scan done, no fracture. Laceration treated. Awaiting to transport resident back to facility."	S9999			

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S9999	Continued From page 6 R1's Progress Note (dated 01/28/2025) documents, "Resident has a laceration to left eyebrow, resident will receive wound care. Physician notified; new orders carried out." R2's Progress Note (dated 01/27/2025) documents, "R2 came to nursing station complaining that she wanted a new room because she did not like her roommate. Writer informed her that social services handled all room changes and she could consult with them as they had not left for the day. She got increasingly upset and wanted something done now. Writer asked the resident what the issue was. R2 stated "I don't have to explain anything to you." Writer informed her again that social services can help her. She then stated; "What if I just go beat her a**." Writer informed the resident that would be a bad idea because of the possibility of police involvement and expulsion from the facility. R2 came back to nursing station and called her mother telling her that she was going to attack her roommate. She began pushing items off the counter and knocking CNA's (Certified Nursing Assistant) belongings on the floor on her way back to her room. Writer called social services to inform them of the situation and impending issue. While on the phone with social services, writer heard yelling and items falling coming from residents' room. Writer went to room and saw R2 holding her roommate by her hair and back of her pants tossing her out into the hallway. Writer stood between the two residents to prevent further assault until social services arrived. The residents were then separated. R2 was in the care of social services. R2 chose to sign out AMA (Against Medical Advice). Family stated to call her when R2 returns. Received police report number. Resident gone when Chicago Police Department	S9999		

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S9999	Continued From page 7 & EMS Arrived." R1's Emergency Room Patient Discharge Summary (dated 01/28/2025) documents in part: Chief complaint/diagnosis: Assault. Discharge diagnoses: Acute head trauma/ Acute knee pain. (B)	S9999			