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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 Annual Certification/Licensure	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 6 300.650d) Section 300.650 Personnel Policies d) The facility shall check the status of all applicants with the Health Care Worker Registry prior to hiring. This requirement was NOT met as evidenced by: Based on interviews and record reviews, the facility failed to provide evidence that they checked the status of five staff members (V24, V25, V26, V27, V28) with the Health Care Worker Registry prior to hire date for five out of ten staff members reviewed for Health Care Worker Background Checks. Findings include: On 3/05/2025 at 11:06 AM, V16 (Human Resources Manager) stated facility is supposed to check applicants on the Health Care Worker Registry prior to date of hire. Surveyor reviewed ten staff members with V16 on 3/05/2024 at 11:06 AM and 1:34 PM. Facility hired V24 (Dietary Aide) on 1/29/2025. V24's Health Care Worker Registry printed forms document in part that the facility conducted the registry check on 2/03/2025 (after the hire date).	S9999		

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S9999	Continued From page 1 Facility hired V25 (Dietary Aide) on 2/26/2025. V25's Health Care Worker Registry printed forms document in part that the facility conducted the registry check on 3/03/2025 (after the hire date). Facility hired V26 (Certified Nurse Aide, CNA) on 1/15/2025. V26's Health Care Worker Registry printed forms document in part that the facility conducted the registry check on 1/18/2025 (after the hire date). Facility hired V27 (CNA) on 1/29/2025. V27's Health Care Worker Registry printed forms document in part that the facility conducted the registry check on 2/03/2025 (after the hire date). Facility hired V28 (CNA) on 2/19/2025. V28's Health Care Worker Registry printed forms document in part that the facility conducted the registry check on 2/21/2025 (after the hire date). Facility's undated "Hiring Policy and Procedures" document in part: "Reference checks - A final candidate for the position will have their background checked by the human resources manager in the Illinois Department of Public Health Healthcare Worker Registry (HCWR)." "Job offers - After a decision has been made to hire a candidate, an offer will be made contingent on the satisfactory completion of required background checks and testing." "Once the human resources manager receives satisfactory results from all required background checks and tests, candidate will be provided with a final job offer." (C) Statement of Licensure Violations 2 of 6	S9999		

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S9999	Continued From page 2 300.1810 m) Section 300.1810 Resident Record Requirements m) All Cook County facilities with Colbert Class Members shall provide educational materials and information to all Colbert Class Members voluntarily or involuntarily discharging from the facility at the time of completing the discharge paperwork, informing them of their rights and services under the Colbert Consent Decree, as prescribed by the Colbert Lead Defendant Agency. All Cook County facilities shall provide written verification of educational materials and information given to the Colbert Class Members, as requested by a Colbert Defendant Agency. These requirements were NOT met as evidenced by: Based on interviews and record reviews, the facility failed to provide educational materials and information to a Colbert Class Member (R284) who involuntarily discharged from the facility. Findings include: R284's Admission Record documents in part a discharge date of 2/20/2025. On 3/05/2025 at 10:11 AM, V15 (Psychiatric Rehabilitation Services Coordinator) stated R284 was working with a transition agency under the Colber Consent Decree for housing. V15 stated R284 discharged elsewhere prior to getting the housing. R284's progress note dated 2/16/2025 11:13 AM,	S9999		

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documents in part that V4 (Social Services Director) provided R284 with an immediate involuntary discharge upon leaving the facility on 2/11/2025. Progress note dated 2/11/2025 11:48 AM, documents in part that the facility sent R284 to the hospital for physical and verbal abuse with petition. Progress notes from 2/11/2025 to current do not document in part that the facility provided R284 with educational materials and information informing R284 of rights and services under the Colber Consent Decree prior to the involuntary discharge.

On 3/05/2025 at 2:51 PM, V1 (Administrator) wrote that the facility did not educate R284 on Colbert Consent Decree at time of discharge.

Facility's "Pre-Admission Screening and Resident Review (PASRR) policy" (last revised 12/2023) documents in part facility's role in submitting census data to the Illinois Department of Public Health's appointed company to be compliant with Colbert Consent Decree. However, it does not document in part procedure to provide educational materials and information to all Colbert Class Members voluntarily or involuntarily discharging from the facility at the time of completing the discharge paperwork, informing them of their rights and services under the Colbert Consent Decree, as prescribed by the Colbert Lead Defendant Agency. Facility did not provide any other policy pertaining to Colbert Consent Decree.

(C)

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Section 300.1060 Vaccinations

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e) A facility shall distribute educational information provided by the Department on all vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (available at: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf), including, but not limited to the risks associated with shingles and how to protect oneself against the varicella-zoster virus. The facility shall provide the information to each resident who requests the information and each newly admitted resident. The facility may distribute the information to residents electronically. (Section 2-213(e) of the Act)

f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and (HIV), and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act)

g) All persons determined to be susceptible to the hepatitis B virus shall be offered immunization within 10 days after admission to any nursing facility. (Section 2-213(c) of the Act)

This requirement was NOT met as evidenced by:

Based on interview and record review, the facility failed to provide evidence that they educated residents and their representatives regarding the risks associated with shingles and how to protect the residents against the varicella-zoster virus, failed to screen and document risk factors associated with hepatitis B, hepatitis C, and Human Immunodeficiency Virus (HIV), and failed to offer immunization within ten days after

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admission for residents who are susceptible to hepatitis B for five (R61, R332, R156, R44, R85) out of five residents reviewed for immunizations. These failures could potentially affect all 175 residents residing in the facility.

Findings include:

On 3/5/2025 at 9:24 AM, surveyor requested from V2 (Director of Nursing/Infection Preventionist) for R61, R332, R156, R44, and R85's shingles education or shingles vaccine information, hepatitis and HIV screenings, and hepatitis B immunization information. Facility did not provide the requested documents. V2 stated that the facility does not screen residents for hepatitis and HIV. V2 also stated that the facility does not offer immunizations for shingles and hepatitis B.

R61, R332, R156, R44, and R85's immunization history in their electronic health records (EHR) did not include shingles and hepatitis B vaccines information/education. R61, R332, R156, R44, and R85's EHRs have no documentation to show that the facility screened them for hepatitis B, hepatitis C, and HIV.

The facility did not provide policy and procedure related to shingles and hepatitis B immunizations for residents.

The facility's "Screening Policy for Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV) Risk Factors" (no date) documents in part: Screen residents who are admitted to the facility upon request of resident/family/representative for at least 7 days for hepatitis B, hepatitis C, and HIV. Obtain a physician referral for testing and immunization, as needed. The physician must ensure that all HIV testing is done in compliance

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S9999	Continued From page 6 with AIDS Confidentiality Act. Document in the medical record if the resident was immunized for hepatitis B. The facility's residents' roster printed on 3/4/25 shows a total of 175 residents residing in the facility. (C) Statement of Licensure Violations 4 of 6 300.615e) 300.615f) 300.615g) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.	S9999		

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g) If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check, unless the fingerprint check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check.

This Requirement was NOT MET as evidenced by:

Based on record review and interview, the facility [A] failed to obtain Criminal History Information Response Process (CHIRP) reports within 24 hours of admission for 4 [R47, R49, R283, R286] out of five residents [R172] residents reviewed in the sample of 35.

Findings include,

On 3/6/25 at 10:00 AM V4 [Social Service Director] provided the following documents:
R47 admitted on 2/20/24. CHIRP completed on 5/13/24 resulted with a HIT.
R49 admitted on 1/24/25. CHIRP completed on 1/27/25 resulted with a HIT.
R283 admitted on 1/17/25. CHIRP completed on 1/19/25 resulted with a HIT.

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R286 admitted on 9/21/24. CHIRP completed on 3/6/25 resulted with a HIT.

On 3/6/25 at 11:30 AM, V1 [Administrator] stated, "I am responsible to complete the new admitted resident's Criminal History Background Check [CHIRP]. R47, R49, R283, R286's CHIRPs were not completed within twenty-fours hours as required. The date at the top of the Criminal History Information Response Process (CHIRP) is the date requested and date received."

Identified Offender policy.
It is the policy of this facility to establish a resident sensitive and resident secure environment. Conduct a criminal history background check within 24 hours of admission. Once the facility determines the resident is an identifier offender the facility must request within 72 hours for the resident to undergo live scan state and Federal Bureau of investigation fingerprint check on the premises within 5 business days.

(C)

Statement of Licensure Violations 5 of 6

300.625c)2
300.625g)

Section 300.625 Identified Offenders

c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following:
2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name,

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sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files.

g) Facilities shall maintain written documentation of compliance with Section 300.615 of this Part.

This Requirement was NOT MET as evidenced by:

Based on interviews and record reviews, the facility failed to arrange fingerprinting within 72 hours of the positive Criminal History Information Response Process (CHIRP) for 2 [R47, R49] residents who had a positive CHIRP in a total sample of five residents.

Findings include:

On 3/6/25 at 10:00 AM V4 [Social Service Director] provided the following documents:
R47 admitted on 2/20/24. CHIRP completed on 5/13/24 resulted with a HIT. Fingerprints ordered on 6/5/24.
R49 admitted on 1/24/25. CHIRP completed on 1/27/25 resulted with a HIT. Fingerprints ordered on 2/3/25.

On 3/6/25 at 10:00 AM V4 [Social Service Director] stated, "If the resident's CHIRP come back with a positive HIT, I have to order the fingerprints within seventy-two hours. R47 and

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S9999	Continued From page 10 R49 was not ordered timely." Identified Offender policy. It is the policy of this facility to establish a resident sensitive and resident secure environment. Conduct a criminal history background check within 24 hours of admission. Once the facility determines the resident is an identifier offender the facility must request within 72 hours for the resident to undergo live scan state and Federal Bureau of investigation fingerprint check on the premises within 5 business days. (C) Statement of Licensure Violations 6 of 6 300.610a) 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	S9999		

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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.

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 interviews and record reviews, the facility failed to protect one (R40) resident's right to be free from physical abuse out of one sampled resident. R132 slapped R40 on the face that resulted in R40's falling on her back and sustained left elbow, back, and neck pain. R40 felt scared and shaken.

Findings Include:

The facility's incident investigation report dated 3/3/25 documents in part: On 3/3/25 [V1 Administrator] was notified by [R40] that [R132] pushed [R40] down. Both residents' representatives and the police were notified. R40's Minimum Data Set (MDS) dated 12/26/24 shows R40 is cognitively intact with BIMS (Brief Interview for Mental Status) of 15 and requires supervision with walking. R40's functional assessment dated 12/26/24 shows R40 had no

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limitation with range of motion to upper extremities. R40's progress notes dated 3/3/25 at 4:39 PM documented by V10 (Psychiatric Rehabilitation Services Coordinator) reads in part: "Resident had an altercation with another resident this morning. Resident was redirected and was checked by nurse. The writer will continue to assist resident's needs."

R132's MDS dated 12/18/24 shows R132 is cognitively intact with BIMS of 15 and independent with walking. R132's progress notes dated 3/3/25 at 10:30 AM documented by V13 (Registered Nurse/RN) reads in part: "Patient came to the medication cart where other patients was standing in line for their medication and stated I want my medication now, I am not waiting. [R132] started yelling and became aggressive with another resident slapped her [R40] in her face and pushed her to the floor."

On 3/4/25 at 10:55 AM, R40 stated on 3/3/25 at around 10:00 AM, R40 was in line to get medications from V13 (Registered Nurse). R40 stated, [R132] "came up real fast next to [V13] and said [R132] needs her medication. [R132] was loud and angry. [V13] tried to tell [R132] that [V13] will finish giving my meds. [R132] was so angry and demanding her meds. I said please have some respect the nurse was telling you something. Then [R132] took her hand, slapped me on my face, and pushed me real hard and knocked me out on my butt. I fell on the ground. I fell on my butt and back and left shoulder. I had a replacement surgery there it's very very painful. Now the pain level is 8. I landed on my left side. Now my left side of my neck, my left side of my mid to lower back and my left elbow is hurting. I was so scared, and I was shaken. [R132] was twice as big as me. [R132] was double the frame

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of me. I'm only 124.8 pounds. I screamed for pain. [V13] the nurse and another staff helped me up. I stood for a while. I slowly walked to my room and laid down. I didn't want to go to the hospital. I told [V13] I was having pain. [V13] gave me Hydrocodone. I already have chronic pain on my left arm but it got worse because of the incident. My elbow, my neck, my back are hurting more." R40 stated the pain medications help control the pain. R40 stated [V13] sent [R132] to the hospital. Surveyor asked R40 to lift R40's left arm and noted R40 with limitation on range of motion.

On 3/5/25 at 9:34 AM, interviewed V10 (Psychiatric Rehabilitation Services Coordinator/PRSC) about the incident that happened on 3/3/25 between R40 and R132. V10 stated, "It was around 10:15 to 10:30 in the morning it happened at the nurses' station on the 5th floor. Front desk paged social service to go to the fifth floor. When I came up there they had the residents [R40, R132] separated already. [V13] and the [Certified Nursing Assistant] CNA (does not know her name) were there they witnessed the incident. [R40] was a little shaky she told me that [R132] pushed [R40]. [R132] was being disrespectful to [V13] and [R40] told [R132] to be more respectful and then [R132] got angry at [R40] and proceeded to pushing [R40] on the face. [R40] told me she fell and hurt her left shoulder and left elbow. [R132] was already in the room and [R40] was in the hallway sitting on the chair with [V13]. The nurse was assessing [R40]. [R40] said that she was okay but [R40] said she was hurting on her left shoulder and left elbow. [R40] did not want to go to the hospital. We kept them separated. After that I started the petition for [R132]. We removed [R132's] roommate from the room because [R132] was still agitated." V10 stated that physical abuse is when someone put

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 _____	03/07/2025

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
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their hands on somebody attempting to hurt them in a malicious way. V10 stated that what [R132] did to [R40] is a type of physical abuse. A follow up interview was conducted with V10 on 3/6/25 at 9:55 AM and stated that R132 had history of aggressive behavior prior to the incident with [R40].

On 3/6/25 at 9:29 AM, a phone interview was conducted with V13 (RN) about R40 and R132's incident on 3/3/25. V13 stated, "It happened in the morning time. I was passing medication when it happened. [R132] came up to me and wanted me to stop to give her medications. I told [R132] that there is a line and people are in line waiting. [R132] started saying she will punch me on my face. [R40] tried to stop [R132] and told [R132], Oh no you can't talk to the nurse like that. Then [R132] slapped [R40] on the face and pushed her. [R40] fell on her back, I think on her left side." V13 stated she assessed [R40] with no injuries and did not complain of pain. V13 stated R40's doctor was notified but R40 did not want to go to the hospital. V13 stated R132 was sent to the hospital for psychotic behaviors.

The facility's "Abuse Prevention Program Facility Policy" (no date) documents in part: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Physical Abuse

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 _____	03/07/2025

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S9999	Continued From page 15 is the infliction of injury on a resident that occurs other than by accidental mends and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. (B)	S9999		