Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUSTIN OASIS, THE	**901 SOUTH AUSTIN BLVD , CHICAGO, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation 25811206/2670746	S0000		01/08/2026
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. 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.	S9999		01/08/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 These requirements were not met as evidenced by: Based on interviews and record review, the facility failed to prevent one resident (R4) from being physically attacked in an elevator. This failure has resulted in R4 sustaining a closed head injury, becoming emotional and stating that she is no longer comfortable in the facility. This failure has affected one (R4) of four residents reviewed for abuse. Findings include: R4 is a 39-year-old with diagnosis including but not limited to: epilepsy, cerebral infarction, transient cerebral ischemic attack, headache and benign neoplasm of cerebral meninges. R4 has a BIMS (Brief Interview of Mental Status) score of a 12, which indicates moderately impaired. R7 is 42-year-old with diagnosis including but not limited to: Unspecified behavioral and emotional disorders, unspecified intellectual disabilities, bipolar disorder, oppositional defiant disorder and morbid/ severe obesity. R7 has a BIMS score of 0 indicates severe cognitive impairment. On 12/08/25 at 12:10 pm, R4 stated the following as she started to cry, “It’s horrible here, I’m miserable! Just a couple of weeks ago, I was attacked on the elevator by a male resident who is about six feet tall and weighs over 300 pounds. He (R7) punched me all in my head and my face. I couldn’t do nothing but scream out for help and no one could help me because the elevator was so crowded. That’s why I have anxiety riding the elevator now. My friend (R5) rides the elevator with me now because I asked to have my meals on the unit and was told that I can’t eat on the unit even though a few other residents are allowed to receive their meal trays on the unit. After R7 attacked me, they (facility) sent him (R7) out for a psychiatric evaluation but he returned right back after a week. The only reason that he (R7) is not here now is because he left AMA (Against Medical Advice) on his own. I’m afraid and traumatized since the attack and I feel targeted. I have been threatened by a couple other male residents since the attack because everyone knows what happened. This place is filled with mental patients and I don’t feel safe here.” On 12/10/25 at 2:15 pm, V8 (Nurse Practitioner) stated	S9999		

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S9999	Continued from page 2 the following, “It is never ok for a resident to be attacked by another resident. If a person is hit in the head, we send them out for further evaluation and a CT scan because you never know what is going on underneath. Many things such as headaches, seizures, visual problems may occur when a person is hit in the head and it could lead to more serious outcomes.” R4’s Care Plan documents, the resident’s (R4’s) comprehensive assessment reveals a history of suspected abuse and/or neglect or factors that may increase her susceptibility of abuse. Neglect. Preliminary Incident Investigation Report dated 11/15/25 documents the following, Residents involved: R4 and R7. It was reported that R4 and R7 were involved in an altercation on the elevator. R4 was noted to have a scratch on the right side of her head in relation to the incident. Incident Investigation Form dated 11/15/25 and documents the following: V15 (PRSC/ Psychiatric Rehabilitation Services Coordinator) stated, R4 and R7 were coming upstairs after eating lunch in the elevator R7 and R4 got into it with one another, then R7 started hitting her (R4) from behind.” Statement of Witness dated 11/15/25 documents the following by V14 (Housekeeper), “when I came off of lunch break, I was standing at the elevator. R7 was making verbal threats to R4 after R4 told R7 to move from in front of the elevator because she (R4) could not get on. R7 told R4 that he would get another resident to fight R4. Once inside the elevator, R4 and R7 keep making verbal threats and then R7 hit R4 in her head (right side) twice with his cane.” Police Report dated 12/11/25 documents R4 as the victim in a simple battery incident. R4’s Progress Note dated 11/15/25 documents R4 was sent out to hospital due to having headache and sensitivity to light. R4’s family, Medical Doctor and Director of Nursing made aware; R4 returned to the facility with Minor Closed Head Injury. Hospital Record indicates R4 was transmitted to the hospital Emergency Department via ambulance on 11/15/25 at 1935 (7:35 PM); R4 seen in the hospital for headache and a diagnosis of minor closed head injury. Petition for Involuntary Admission dated 12/15/25 at 12:30 pm documents, R7 in need of immediate hospitalization for the prevention of harm; R7	S9999		

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S9999	Continued from page 3 presenting with verbal and physical aggression, continuing to escalate despite attempts to de-escalate; R7 having bizarre delusions about other residents; R7 is presenting with labile mood. AMA (Against Medical Advice) Form dated 11/15/25 documents, R7 signing himself out AMA. R7's Nursing Progress Note dated 11/21/25 documents, R7 returned from the hospital; R7 left AMA. Abuse Prevention Program Policy documents, 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. (B)	S9999		