STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145834	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Austin Oasis, The	901 South Austin Blvd Chicago, IL 60644

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067 Based on interview and record review, the facility failed to ensure that a resident was free from physical abuse. This failure affected R3 who was physically punched and pushed by R8, causing R3 to fall and sustained a left hip fracture and right finger fracture that required emergency transfer to the trauma hospital with surgical repair of the left hip fracture and right finger fracture when reviewed for physical abuse in the sample of 4 residents (R3, R6, R7 and R9). Findings include: On 4/16/24 at 11:22 am, R3 stated that a while back, R3 broke R3's hip and that it was hurt real bad. When asked about the hip fracture, R3 stated that R3 was hit by R8 when R8 knocked the h*** out of R3. R3 confirmed with this surveyor that this occurred on 4/10/2020. R3 stated that it was on R3 and R8's floor, down the hallway by the entryway to the stairs, and that R3 was not bothering anyone. R3 stated that R8 punched R3 first and that R3 then tried to stop R8 from hitting R3 again when R3 fell to the floor, saying down I (R3) went. R3 stated that staff came to break it up and that R3 had immediate pain on R3's left hip and right hand. R3 stated that R3 went to the hospital and had surgery on R3's left hip. R3's Admission Record, documents, in part, diagnoses of seizures, mild protein-calorie malnutrition, schizoaffective disorder, major depressive disorder, dysphagia, pain in right hip, hypokalemia, fracture of part of left femur neck, displaced fracture of base of 5th metacarpal bone of R hand and paranoid schizophrenia. R3's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview of Mental Status (BIMS) score of 11 which indicates that R3 has moderate cognitive impairment. R3's MDS, dated [DATE], documents, in part, a BIMS score of 12 which indicates that R3 has moderate cognitive impairment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/17/24 at 2:42 pm, V20 (Former Employee, Licensed Practical Nurse, LPN) stated that V20 worked in facility through 2021 and does remember R3 and R8's physical altercation on 4/10/2020. V20 stated that V20 was at the nurse's station which was at the other end of the hallway, and V20 responded immediately to R3 and R8's altercation and observed R3 on the floor. V20 stated that R3 was trying to get up from the floor but could not move due to the pain. V20 stated that other staff, including V19 (Certified Nursing Assistant, CNA) were present separating R8 from R3. V20 stated that R3 was complaining of pain to R3' left hip and right hand. V20 performed assessment, vital signs and that V20 called 911 for R3's emergent transfer to the hospital. V20 stated that V20 assessed R8 too, and R8 informed V20 that there was another resident, R13, who R3 was talking to in the hallway, and that R8 punched (R3) and knocked (R3) down to the ground. V20 stated that both R3 and R8 were both liking (R13). In R3's Progress Note, dated 4/10/2020 at 2:44 pm, V20 (LPN) documents, in part, that R3 and R8 were involved in a physical altercation in the hallway, and that V20 assessed (R3), laying on the floor, complaining of right hand and left hip pain with physician orders to send R3 via 911 to the hospital. In R3's Progress Note, dated 4/10/2020 at 3:09 pm, V20 (LPN) documents, in part, that V20 was informed by hospital staff that R3 was being transferred to a trauma hospital due to R3's left hip fracture and right pinky fracture. R3's trauma hospital records, document, in part, that on 4/14/2020, R3 has surgical repair of R3's left hip fracture (hemiarthroplasty pinning surgery) and R3's right 5th metacarpal fracture (closed reduction and external fixation pinning surgery). Hospital records document, in part, that R3's fractures are result of a physical altercation with R3 being assaulted in the facility by another resident (R8), and that R3 stated that R8 started the physical altercation. R8's Admission Record, documents, in part, diagnoses paranoid schizophrenia, hyperlipidemia, dysarthria, hypertension, benign prostatic hyperplasia with lower urinary tract symptoms, osteoarthritis, insomnia, bipolar disorder, abnormal posture, obstructive and reflux uropathy, chronic obstructive pulmonary disease, acute sinusitis, drug induced subacute dyskinesia, and flaccid neuropathic bladder. R8's MDS, dated [DATE], documents, in part, a BIMS score of 15 which indicates that R8 is cognitively intact. R8's Screening Assessment for Indicators of Aggressive and/or Harmful Behaviors, dated 3/9/2020, documents, in part that R8 has a history of presence of dysfunctional behavior (e.g. {for example} provoking, aggressive, manipulative, derogatory, disrespectful, obnoxious, abhorrent, insensitive, attention-seeking, and/or otherwise abrasive/inappropriate behavior) including roaming/wandering into peer's room/personal space. R8's Census documents, in part, that R8 was discharged from the facility on 11/7/2022 and was not able to be interviewed. In R8's Progress Note, dated 4/10/2020 at 2:35 pm, V20 (LPN) documented, in part, that (R8) was in a physical altercation with peer (R3) in the hallways, (R8) stated 'peer (R3) was talking to R8's lady (R13) friend'. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/17/24 at 11:04 am, V19 (CNA) stated that V19 was routinely working on R3 and R8's floor in 2020 and does remember a physical altercation between R3 and R8 with V20 being the nurse on 4/10/2020. V19 stated that R8 used to walk around the floor, was difficult to redirect and didn't want to take no for an answer. V19 stated that on 4/10/2020, V19 responded to R3 and R8's physical altercation at the end of the hallway (by the stairwell) with R3 on the floor. V19 stated that V19 was unsure if R3 lost R3's balance, and that V19 broke it up between R3 and R8. V19 stated that R8 did have a friend (R13) that R8 was always around and R13's room location was in the hallway area where R3 and R8 had a physical altercation. Facility roster, dated 4/10/2020, and R3 and R8's Census reports document that R3, R8 and R13 were all residing on the same floor on 4/10/2020. R13's Admission Record documents, in part, that R13 was discharged from the facility on 10/22/2020. On 4/17/24 at 2:42 pm, V20 (Former Employee, LPN) stated that V20 worked in facility through 2021, and that V20 does recall R3 and R8's physical altercation on 4/10/2020. V20 stated that V20 was at the nurse's station at the other end of the hallway. V20 stated that V20 responded immediately and observed R3 on the floor and was trying to get up from the floor but could not due to pain. V20 stated that other staff were present separating R8 from R3. V20 stated that R3 was complaining of pain to left hip and right hand. V20 performed assessment, vital signs and that V20 called 911 for R3's transfer to the hospital. V20 stated that R8 informed V20 that there was another resident, R13 (whose room was the first room down that hallway, next to R8's room), who R3 was talking to in the hallway, and that R8 punched (R3) and knocked (R3) down to the ground. V20 stated that both R3 and R8 were both liking (R13). On 4/18/24 at 11:07 am, when asked if a resident has the right to be free from physical abuse, V2 (Director of Nursing, DON) stated, Absolutely. V2 stated that facility staff prevent physical abuse from happening by monitoring residents and intervening and separating when residents before it escalates into a physical altercation. On 4/18/24 at 1:14 pm, V1 (Administrator) stated that V1 is the abuse coordinator for the facility. When asked about residents admitted to and residing in the facility, how are staff ensuring that residents are not being abused, and V1 stated, It's harm and safety. We make sure that residents are safe. That their rights are not violated. That they are not harmed. That they are getting care. And not getting beat up. In R3/R8's physical abuse report to the state agency, dated 4/10/2020, V16 (Former Administrator) documents, in part, that V20 reported that (R8) allegedly punched and pushed (R3) down to the floor while passing in the hallway with resident injuries or complaints of injury as (R3) complains of right hand pain and left hip pain. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Facility policy, date 2011 and titled Abuse Prevention Program Facility Policy, documents, in part, Policy: This facility affirms the right of our residents to be free from abuse . This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment . The facility is committed to protecting our residents from abuse by anyone including, but not limited to, . other residents . Definitions: . Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention . Physical abuse includes hitting, slapping, pinching, kicking.