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	12/23/2024

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** 30279 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 [DATE] with latest recorded admitted [DATE]. 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, 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 admitted as 08/22/2023 and latest admitted [DATE] 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. (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	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 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 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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. 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279 Based on observation, interview, and record review the facility failed to administer right dosage of a prescribed medication as per physician order for one resident (R3,) out of three residents reviewed. This failure affected R3 who has a physician order to receive Ibuprofen oral tablet 800mg (milligrams) as needed every eight (8) hours for pain but was administered 600 mg instead with potential that R3's pain may not be controlled. Findings include: R3's medical record Admission Record showed that R3 was admitted to the facility on [DATE]. Listed diagnosis includes but not limited to chronic obstructive pulmonary disease, bipolar disorder, Anemia, progressive vascular leukoencephalopathy and anogenital herpes viral infection. On 12/16/24 at 1:05pm, R3 was observed on the 4th floor at the nurse's station requesting for pain medication Ibuprofen from V13 LPN (Licensed Practical Nurse). V13 checked the order and proceeded to prepare the medication. V13 looked for the medicine it was unavailable. V13 found ibuprofen 200mg/tablet bottle from the facility house stock. V3 prepared three tablets and administered it to R3 when the surveyor brought this to V13, asking V13 to clarify the order with surveyor watching the R2's electronic medication order. V13 confirmed that that R3 is supposed to get 800 mg. V13 stated I don't know whether to give R3 all the 800 mg because it usually comes as one tablet and giving (R3) equivalent of 800 mg will be four tablets that is why I gave three tablets (600mg). On 12/16/24 at 1:08pm, The surveyor asked what the facility policy/protocol of medication administration is. V13 stated that the medication should be given to resident as ordered in ordered dose. V13 stated that the 800 mg has not been refilled since November 30th by the pharmacy. V13 stated we have been given R3 acetaminophen because R3 has orders for it too. The surveyor asked what the facility policy/protocol of medication administration is. V13 stated that the medication should be given to resident as ordered in ordered dose. V13 stated, that the 800 mg has not been refilled since November 30th, 2024, by the pharmacy. On 12/16/24 at 1:15 pm, V13 signed out R3's medication has been given 800 mg. R3 medical record Order Summary Report showed that R3 has order for Ibuprofen oral tablet 800mg give one tablet by mouth every 8 hours as needed (PRN) for pain with ordered date 11/30/23 and no end date. On 12/16/24 at 1:30pm, when this was brought to V2 DON (Director of Nurse's) attention and was asked about facility policy /protocol on medication administration. V2 stated in part the medications are to be administered according to physician order and the right dose should be administered. V2 stated that it is not acceptable for any nurse to take upon themselves to change the medication dosage without physician order. V1 (administrator) who was present at the time of interview and V2 then stated that V13 will be asked to add the remaining 200 mg to make 800 mg to control R3's pain. V2 stated that the pharmacy will also be notified to refill for 800 mg because it comes in one big pill because of the strength. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 12:00 pm, the surveyor asked V3 NP (Nurse Practitioner) if in her own professional opinion is it appropriate for a nurse to change medication dosage for the resident. V3 stated Not without an order from the physician. Facility policy on Ordering and receiving Non-Controlled Medications from the Dispensing Pharmacy presented with effective date 10/25/2014 documented that the policy is for medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. The facility policy on Medication Administration dated 8/15 presented documented that medications must be administered in accordance with physician's order at his /her discretion that includes but not limited to right dosage. The facility policy on Physician Orders dated 6/17 documented listed guidelines to ensure that the physician order includes but not limited any orders given by physician are carried out.