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	01/22/2026

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by a staff. This failure affected 1 (R2) resident reviewed for abuse and has the potential to affect all 34 residents on the 5th floor who smoke.The (undated) Patio/Smoking Schedule documented that there were 34 residents who smoke on the fifth floor.R2's (12/10/2025) Final Incident Investigation Report documented, in part (R2) alleged that a facility member called him a profane name. Calling residents kids when overseeing the cigarette line. Resident (R3) was interviewed him being there at the time of the incident. (R3) stated (V4-Former PRSC Psychiatric Rehabilitation Services Coordinator) was verbally aggressive towards residents. (R4) stated (V4) was rude and did not know how to talk to people. The facility was able to substantiate the allegation due to witness testimony. (R3)'s statement (V4) use derogatory language towards everyone in line, including (R2). Called the wrong floor to smoke, 5th floor came to smoke. (V4) got upset and started cursing. (V4) said she was sick of this S***. When (R2) came around the corner she (V4) really got upset and was calling people F***** kids. On 01/14/2026 at 2:35pm, R3 stated the receptionist called for 5th floor residents to go down to smoke. When they got on line to the smoking area, she (V4) said ‘what are you doing mother f***r and also said they were acting like kids. He (R2) and (V4) were talking back and forth.On 01/14/2026 at 3:25pm, R2 stated there was a miscommunication between the front desk and (V4). The front desk called (overhead paged) for one floor to smoke, and she (V4) called for another floor to smoke. R2 stated he went down to the first floor and got in line, was talking to other residents about energy and people's character and just out of the blue she (V4) told him (R2) Little boy, watch the F*** you are saying. R2 stated it just escalated from there. R2 stated he felt disrespected by (V4).On 01/20/2026 at 2:33pm, V3 (Social Services Director/Administrator-in-Training) stated staff are not supposed to tell residents they are like children because it is demeaning and that is a dignity issue. On 01/15/2026 at 2:49pm, V1 (Administrator) stated they (R2, R3, R4) were in the smoking line and she (V4) was cursing telling them to get in line, you are all acting like F****kids. He (R2) took offense and told her, who are you talking to, don't talk to me like that. and she (V4) went to him aggressively basically saying ‘if you don't like it here, be somewhere else. V1 stated he was taking all stories including (R3) and he (R3) said she was verbally aggressive. He intervened and escorted him (R2) away. V1 stated he asked (R4) and he said she (V4) talked crazy all the time. V1 stated with these testimonies, he substantiated the allegation, and she was terminated. Her last day was on 12/09/2025. It is not expected of staff to verbally abuse residents, and her aggressive behavior affected him (R2) and could potentially affect all the smokers on the 5th floor. R2's admission Record documented that R2's diagnoses (include but not limited to) alcohol abuse, asthma, and Type 2 Diabetes Mellitus.R2's (12/03/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 15. Indicating R2's mental status as cognitively intact. R3's admission Record documented that (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 - Minimal harm or potential for actual harm Residents Affected - Some	R3's diagnoses (include but not limited to) disorder of kidney and ureter, hypertension, and nicotine dependence.R3's (10/15/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 15. Indicating R3's mental status as cognitively intact.R4's admission Record documented that R4's diagnoses (include but not limited to) major depressive disorder, bipolar disorder, and alcohol abuse.R4's (11/11/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 06. Indicating R4's mental status as severely impaired.V4's (11/2025 - 01/20260 Timecard (Terminated Employees) documented that V4's last day of work was on 12/09/2025.The (undated) Resident Rights documented, in part Policy: employees shall treat all residents with respect, kindness, and dignity. To provide an environment of care that supports a positive self-image. Policy Interpretation and Implementation: 1. Federal and State Laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ee. The right to an environment that preserves the dignity and contributes to a positive self-image. 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.

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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. Based on observation, interviews, and record review, the facility failed to ensure a resident was administered a medication with a correct dosage. This failure affected 1 (R6) resident reviewed for medication administration in the total sample of 8 resident.On 01/15/2026 at 9:53am, during the medication administration observation with V11 (Licensed Practice Nurse), V11 dispensed R6's medications including Metoprolol 25mg/tab x 1 tablet. R6's container of Metoprolol has instruction written Metoprolol Tartrate 25mg. Take 0.75 tablet (18.75mg) by mouth every 12 hours.On 01/15/2026 at 9:56am, V11 administered R6 medications.ON 01/15/2026 at 10:01am, V11 stated she dispensed and gave Metoprolol 1 tablet to R6. V11 checked the container of R6's Metoprolol and stated he (R6) is supposed to get 18.75mg and she gave Metoprolol 25mg. V11 stated she did not follow the doctor's order.On 01/15/2026 at 10:07am, V12 (Licensed Practice Nurse) stated she works regularly on the second floor and whenever she is assigned to him (R6) she dispensed the medication from the container and gives one whole tablet. V12 stated the whole tablet is already 18.75mg. V12 checked the container of R6's Metoprolol Tartrate and stated she has been giving him (R6) 25mg and she did not follow the order to give Metoprolol 18.75mg.On 01/20/2026 at 11:00am, V2 (Director of Nursing) stated according to the order, he (R6) should get 1/2 tablet and 1/4 tablet of the Metoprolol 25mg, so he would get a total of 18.75mg. The nurse who gave the whole table of Metoprolol 25 mgs did not follow the doctor's order. The expectation is to follow the doctor's order, and if they are giving him the whole tablet, they are not following the doctor's order. Metoprolol is for hypertension and the resident could potentially become hypotensive if given a higher dose.R6's admission Record documented that R6's diagnoses (include but not limited to) hypertension, tachycardia, and dependence on oxygen.R6's (11/19/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 5. Indicating R6's mental status as severely impaired. Section I. Active Diagnoses. I0700. Hypertension.R6's (Active Order as Of: 01/15/2026) Order Summary Report documented, in part Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 18.75 mg by mouth two times a day for HTN (hypertension). Active 09/17/2025. R6's (01/2026) Medication Administration Record documented, in part Metoprolol Tartrate Oral Tablet 25 MG, (Metoprolol Tartrate) Give 18.75 mg by mouth two times a day for HTN (hypertension). Start Date: 09/18/2025 0900. D/C (discontinuation) Date: 01/15/2026.The (undated) Registered Nurse Job Description documented, in part Job Summary: The primary purpose of your job position is to provide direct nursing care to the residents and to supervise the day to day nursing activities performed by the nursing assistants. Such supervision must be in accordance with current federal, state and local standards, guidelines and regulations that govern our facility to ensure the highest degree of quality care. Essential Duties and Responsibilities: 16. Prepare and administer medications and treatments as ordered by Physician. The (undated) LPN Job Description documented, in part Job Summary: The primary purpose of your job position is to provide direct nursing care to the residents and to supervise the day-to-day nursing activities performed by the nursing assistants. Such supervision must be in accordance with current federal, state and local standards, guidelines and regulations that govern our facility to ensure the highest degree of quality care. Essential Duties and Responsibilities: 16. Prepare and administer medications and treatments as ordered by Physician.The (undated) MEDICATION ADMINISTRATION POLICY documented, in part II. ADMINISTRATION OF MEDICATIONS. Medications must be administered in accordance with a physician's order at his/her discretion, e.g., the right resident, right medication, right dosage, right route, and right time.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's environment was free from hazardous material (razor). This failure affected 1 (R5) resident reviewed for supervision and hazard in the total sample of 8 residents. R5 sustained a wide linear abrasion on the left forearm beginning at the base of left thumb and extending to the mid forearm on radial side. The abrasion is approximately 1.5inch in width. R5's admission Record documented that R5's diagnoses (include but not limited to) cannabis dependence, alcohol dependence, alcoholic cirrhosis, and depression. R5's (01/03/20260 Petition for Involuntary/Judicial admission documented, in part a person subject to involuntary in-patient admission to a facility by reason of emergency inpatient admission by certificate. A person with mental illness who because of his or her illness is reasonably expected, unless treated on an inpatient basis to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed. In need of immediate hospitalization for the prevention of such harm. Exhibiting suicidal ideation with attempt to cut/slit her wrist. R5's (01/03/2026) Wound Paired Inspection Form documented, in part Abnormal findings: Small cut wound at the left wrist/abrasion on the left wrist. R5's (01/03/2026) Hospital Record documented, in part history of present illness: she became frustrated and today superficially cut her left wrist. Review of system. Skin: there is a wide linear abrasion on the left forearm beginning at the base of left thumb and extending to the mid forearm on radial side. The abrasion is approx.(approximately) 1.5inch in width. This was done with a razor blade. V1 (Administrator)'s (01/05/2026) email correspondence with V14 (Nurse Practitioner-Psychiatrist) documented, in part This email is sent to inform you that a resident on your caseload named (R5) has been given an emergency IVD for bringing razors into the facility and harming herself. V1's (01/05/2026) email correspondence with V29 (Ombudsman) documented, in part Resident brought razors into the facility and harmed herself. On 01/22/2026 at 8:01am, V27 (Certified Nursing Assistant) stated she worked the 11pm-7am shift, she was doing her rounds, checking her residents. When she got to her (R5) room, she saw her scraping her arm with a razor. She asked her why she was scraping her arm and she (R5) stated she wanted to go to the hospital to be with her boyfriend, (R8). V27 stated she called (V19 - Nurse Supervisor) and he (V10) asked her where she got the razor, and she said she brought it with her to the facility when she went out on pass. V27 stated the razor did not look like the one they used at the facility. That is why she believed her that she got it while she was out on pass. V27 stated that her forearm had a long scratch; there was blood, but it was not gushing. On 01/20/2026 at 3:19pm, V10 (Nurse Supervisor) stated he worked 3-11 and 11-7pm. V10 stated she (V27) was doing her round, went to her room, and she (V27) saw the wound on her (R5) left forearm, as if she ran the razor on her forearm 2x. She (R5) said she got the razor outside. She came back from the community pass with a razor. V10 showed a picture of the blue razor, the handle was straight with label (Brand of Razor). V10 stated the facility is both psych and skilled facility. A resident should have not access to a razor because it is not safe for them, the resident could hurt themselves and other residents and staff. The resident should be safe at the facility at all times, and she was able to hurt herself with a razor.On 01/21/2026 at 2:36pm, V23 (Medical Records/Central Supply) stated she has been the central supply person for 6-7years and the razor she purchased have been the same, curved and not branded because it is cheaper than the branded razor. This surveyor showed the razor used by R5 and stated it was not the razor she purchased for the facility. V23 showed to this surveyor the razor she purchased for the facility. The razor's handle was curved and has no label (brand name).R5's census list documented that R5 was on Therapeutic Leave on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/24/2025 and Returned to the facility on [DATE].R5's (12/24/2025) untitled record documented, in part Time 5:11 (pm). Date return: 12/26/2025. On 01/22/2026 at 3:09pm, V24 (Psychosocial Aide - PSA) stated he worked when she (R5) returned from community pass on 12/26/2025 but he did not do the search on her. V24 stated if she has diagnoses of Cannabis and Alcohol Dependence, she should be searched. V24 stated he never documents the search is completed if there were no contraband. V24 stated he understands if the search was not documented, it means it is not done. V24 stated he was never informed to do extra documentation if they did the search with no findings.On 01/21/2026 at 3:44pm, V26 (PSA) stated he worked on 12/26/2025 and he did not do the search for (R5). V26 stated when the search is completed and there is no findings, he lets the resident go back to the room. V26 stated he never documents the search is completed if there is no findings.On 01/20/2026 at 3:55pm, V3 (Social Services Director/Administrator-In-Training) stated if a resident is on the BMOD (Behavior Modification Program) they have to be searched when they go back from the community to ensure they did not bring drugs, alcohol or any sharp objects like a razor. She (R5) was on a Behavior Modification program because she has diagnoses of cannabis dependence and alcohol dependence and she has to be searched when she returned from a community pass because it is part of her contract. On 01/22/2026 at 5:20pm, V1 (Administrator) stated the Drug Parameter is part of the Behavior Modification (BMOD) Program. V1 stated she did not have Drug Parameter contract nor the BMOD contract signed. She could have been educated about the program. If she (V3) said she (R5) was on the list for BMOD, she should be searched when she returned from the community to ensure she was not bringing contraband in the building. If the search was not documented, then it cannot be confirmed if the search was done. V1 stated the facility should provide the resident with a safe environment. The (undated) Behavior Modification Program Resident Addiction Program Parameters documented, in part Any resident admitting to the facility with a recent drug history (use within 1 year) or a current resident that has violated the facility drugs policy/procedures must follow these guidelines: Parameters for new/admitting residents: Must sign or accept the education of the Drug Parameter Agreement prior to being admitted to the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food items were 6 inches above the floor in an effort to prevent foodborne illness. This failure has the potential to affect all 179 residents taking oral nutrition at the facility. The (01/14/2026) facility census was 180.The undated list of residents on NPO (nothing per mouth) include 1 resident.On 01/15/2026 at 10:28am with V6 (Dietary Manager) inside the Kitchen's walk-in refrigerator, there were stacks of boxes of food items with a box labeled pork/cerdo on the floor. V6 stated boxes of food items should be 6 inches above the floor to prevent food contamination.On 01/15/2026 at 1:24pm V6 stated all food items should be 6 inches above the floor to prevent food contamination and to prevent potential food borne illness. The (Revised 2017) Sanitation and Food Safety Storage of Refrigerated Foods documented, in part Policy: Refrigerated food is stored in a manner that ensures food safety and preservation of nutritive value and quality. Procedure: Food is stored six inches above the floor.