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 _____	C 02/08/2023

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
S 000	Initial Comments FRI of 1/12/2023/IL155523	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b 300.1210d)6 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met as evidenced by: Based on interview and record review, failed to follow their policy to be free from physical abuse by providing necessary care in services thus resulting in a male resident (R2) physically assaulting another male resident (R1) for two (R1 and R2) out of three residents reviewed for physical abuse. Findings include: On 02/07/23 at 10:40 AM, surveyor observed R1 laying on his bed in his room. R1 was not in any pain or discomfort. On 02/07/23 at 10:40 AM, R1 stated that R2 hit him (R1) on the head, and he (R1) started bleeding. He (R1) stated R2 hit him (R1) on the head with his (R2) cane. R1 stated that he (R1) was sent out to the hospital, and he (R1) needed staples on his (R1) head. On 02/07/23 at 11:00 AM, R2 stated that he (R2) did hit R1 on the head.	S9999		

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S9999	Continued From page 2 On 02/07/2023 at 12:11 PM, V2 (Assistant/Interim Administrator) stated that if they have a care plan in place for that particular behavior, we don't update the care plan if we see that behavior. We just follow the interventions. Intervention for R2's behavior was to evaluate, work on improving listening skills, He refuses to take medications, so medication is not an appropriate intervention. If I have a resident is agitated, then I (V2) would reach out to psychiatrist and see what could be changed in his (R2) medications but he (R2) refuses all his medications so that is not an appropriate intervention. R2's current interventions are on-going interventions, to prevent him from being aggressive to anyone. After any incident we don't usually update care plans. V2 stated that R2 acts like he is the boss on his floor. He (R2) tells people what to do. On 02/07/2023 at 12:53 PM, V12 (Registered Nurse) stated that R1 is a resident that eats out of the garbage. So, we have to redirect him (R1) from going through garbage cans. I (V12) was at the nurse's station and there was a garbage can near the nurse's station. I (V12) saw him (R1) go to the garbage can. He (R1) GRABBED a piece of garbage and was about to eat it. He (R1) was determined to eat what he (R1) grabbed. I (V12) took the bag behind the nurse's station and R1 followed me (V12) behind the nurse's station to grab the bag. He (R1) was not trying to attack me. He (R1) was just trying to reach for the bag. R2 saw that and started swearing. R2 then left and then came back and had what looked like in his hands a cane. R2 was yelling at R1 and swearing at him (R1). R2 then swung with the cane and made contact with R1's head. I (V12) then heard a crack. I then saw blood running down R1's neck. I ran into the bathroom and got	S9999		

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S9999	Continued From page 3	S9999		

paper towels to press on his (R1) open wound. I (V12) tried to apply pressure and call a code yellow because I (V12) needed help. The other staff came. We wrapped his (R1) head, called 911 and sent him (R1) out to the hospital and sent R2 out for psych evaluation. V12 stated that R2 is loud and more verbal. I (V12) didn't know that he (R2) had a stick in his (R2) room. They call him (R2) a general and he (R2) thinks he (R2) runs the floor. He (R2) thinks he (R2) is the boss of the floor. If someone gets out of hand, he (R2) usually intervenes and yells at them and they listen.

R2's Facesheet documents in part: Diagnosis: Violent Behavior.

Facility's Final Abuse Incident Investigation Report (1/12/2023) documents in part: It was reported that R2 hit R1 on the head in an attempt to stop him (R1) from going through the garbage. R1 noted with laceration to his (R1) head. First aid provided, sent to ER for evaluation. R2 and R1 were immediately separated. MD notified and new orders noted and carried out. R1 returned from the ER with 2 staples to his (R1) posterior head. Site being monitored for signs and symptoms of infection. Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation, abuse; is substantiated.

Facility reported incident investigation report witness statement by V12 documents in part: I saw R1 come out of his room and go to the garbage can in the hallway on the 4th floor. He (R1) grabbed a bag of garbage and I (V12) took it from him (R1). He (R1) followed me (V12) into the nurse's station and another resident (R2)

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S9999	Continued From page 4 walked up behind him with a long cane and hit R1 on the back of his (R1) head, causing him (R1) to bleed and receive a head injury. He (R1) received two staples to the back of his (R1) head. Facility's abuse policy documents in part: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. Abuse means any physical, mental or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury with resulting by physical harm, pain or mental anguish to a resident. Physical abuse is the infliction of injury upon a resident that occurs by hitting slapping, pinching, kicking, and controlling behavior through corporal punishment. (B)	S9999		