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 01/30/2023

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 1/1/2023\IL155272	S 000		
S9999	Final Observations Statement of Licenusre Violations 300.610a) 300.1210b) 300.3240a) 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirments were NOT MET as evidenced by: Based on interview and record review the facility failed to ensure that residents are free from abuse for two of 8 residents (R1 and R2) in the sample of 8 reviewed for abuse. This failure resulted in R1 being verbally abused by staff using curse words and R2 physically abused by staff, by physically hitting, and punching R2 on the back of the head. Findings include: R1's medical record showed that R1 was last admitted to the facility on 12/06/2017 with diagnosis that includes but not limited to Chronic obstructive pulmonary disease unspecified, unspecified Asthma uncomplicated, Essential (primary) Hypertension, chronic kidney disease, Heart failure, Unspecified Dementia, Unspecified severity, with other behavioral disturbances, Schizophrenia Covid-19, contact with and (suspected) exposure to other communicable disease, underweight, and hemiplegia unspecified affecting right Dominant side. R2's admission record documented that R2 was last admitted to the facility on 12/28/2020 with diagnosis that includes but not limited to Catatonic Schizophrenia, Paranoid Schizophrenia, Abnormal Posture, Unspecified	S9999		

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S9999	Continued From page 2 Dementia, unspecified severity, with other Behavioral Disturbances, Adult to thrive and Strange and inexplicable behavior. On 01/17/2023 at 12:13pm, interview conducted with R1 regarding the incident of 01/01/2023, R1 was unable to express how (R1) felt but stated that (V15) used bad words when talking to (R1). According to the facility Final Incident Investigation Report documentation of the incident of 01/01/2023 at 7:45pm, it showed the incident was reported by another resident identified as R5. R5 reported that V15 LPN (Licensed Practical Nurse) cursed out R1 and it was also witnessed by V17 CNA (Certified Nurse's Aide) and another resident. The facility's presented witness report dated 1/4/23 documented that V17 gave a statement that (R1) kept asking for tubing (referring to the Oxygen tubing). V17 stated that she (V17) heard V15 using a cursed word when talking to R1. V17 stated she (V17) was sitting in the Hallway with another resident identified as (R5), V17 stated that R1 asked about 3 times, and the nurse (referring to V15) kept telling (R1) to wait. Facility investigation concluded that the allegation was substantiated and V15 contract was terminated. Review of abuse book from October 2022 to January 2023 showed that R2 was physically abused by another staff identified as V16 LPN (Licensed Practical Nurse). According to the facility investigation this incident was substantiated, V18 CNA (Certified Nurses Aide) reported to V12 (LPN) that she (V18) witnessed V16 (CNA) physically punching and hitting R2 at the back of the head stating that R2 stole her (V16) money. Facility statement of witness presented and dated 1/9/23 documented V16's	S9999		

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S9999	Continued From page 3	S9999		

statement that she (V16) left her (V16) bag and coat in R2's room. Upon V16 returning to R2's room the bag was opened, and the food was gone. V16 admitted that she (V16) physically touched R2's neck asking why R2 went in her (V16) bag. The final investigation report showed that this incident was substantiated and V16 was terminated.

On 01/17/23 at 1:00pm, R2 was unable to recollect the incident and not willing to talk with the surveyor.

On 01/18/2023 at 10:45am, interview conducted with V1 (Administrator) regarding the facility policy on abuse. When the surveyor asked whether it is appropriate for V16 to physically hit R2, V1 stated that "Absolutely not, completely not tolerated which is why she (V16) was terminated. The surveyor then asked whether this a form of abuse. V1 stated "Yes, it is, and she (V16) has been terminated, V16 has been previously educated on form of abuse. Regarding V15 verbally abusing R1, V1 stated that "She (V15) should not have (referring to verbally abuse of R1). And it is considered a form of abuse. She (V15) was also terminated."

On 01/19/2023 at 9:29am, interview with V1 (Administrator) regarding V16 termination, V1 stated that "V16 had a 13 (thirteen) weeks contract with the facility to work 40 hours per week so the contracted was terminated, V16 cannot come back to work in the facility."

On 01/30/23 at 10:00am, interview with V12 LPN (Licensed Practical Nurse) regarding the incident of 01/09/23, V12 stated that she was the charge nurse at the time and that one of the CNA's (identified as V18) reported the incident stating

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S9999	Continued From page 4	S9999		

that another staff (V16) was being a little not nice and a little bit inappropriate with (R2). V12 stated that during her (V12) investigation, V16 stated that R2 was going through V16's personal belongings. V12 added R2 tends to do that. V12 stated that the incident was reported immediately to V1 and V16 was asked to go down to V2 DON (Director of Nurses) office. V12 acknowledged that hitting any resident by staff is a form of abuse and should be reported immediately to V1. V12 stated that full body assessment was done with no injury noted on R2.

On 01/30/23 at 10:16am, interview conducted with R5 regarding the incident of 01/01/23. R5 stated "I (R5) was sitting not far from the nurse's station. I (R1) asked the Nurse identified as (V15) for (R1) 's breathing treatment. V15 slammed her (V15) hand on the desk told (R1) not to (foul language) ask for any thing (referring to oxygen tubing)".

On 01/30/23 at 10:27am, interview conducted with V18 CNA (Certified Nurse's Aide) regarding the incident of 01/09/2023 involving R2 and V13 (CNA). V18 stated in part that I (V18) was in the dining area with V13, when I turned around V13 was standing over (R2) who was sitting by the table. V13 was punching and slapping R2 and speaking in another language that is not English, all I (V18) could understand was "where is it?". V13 continued to slap and punch R2 on the back of the head. V18 stated that I (V18) told V13 not to hit R2 like that. V18 stated that she then reported it to the Nurse identified as V12 (LPN). When the surveyor asked about R2's reaction to V13 physically abusing R2. V18 replied R2 is non-coherent confused and not fully alert. V18 stated R2 cannot hold conversation but can make needs known. V18 acknowledged that physically

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hitting any resident by either the staff, family or another resident is a form of abuse, and it should be reported immediately.

On 01/30/23 at 10:56am during interview with V19 (LPN) and MDS Coordinator, regarding whether hitting resident is an abuse. V19 stated that "hitting a resident by staff is a form of abuse and should be reported immediately to V1 (Administrator).

On 01/30/23 at 11:08am, interview with V1 (Administrator), V1 acknowledged that it is not appropriate for staff to keep their personal belongings in the resident rooms. That there is a facility locker room downstairs in the facility provided for staff or the staff should not bring their belongings into the facility.

R5's facility assessment tool used in assessing all resident MDS (Minimum Data Set) dated December 31, 2022, showed that R5 has a BIMs (Brief Interview for Mental Status) summary score of 15.
R2's facility assessment tool used in assessing all resident MDS (Minimum Data Set) dated December 21, 2022, showed that R2 has no score recorded for BIMs (Brief Interview for Mental Status).

On 01/30/23 at 10:56am, interview with V19 MDS Coordinator regarding R2's BIMS score why there was no numerical score entered. V19 stated in part that when a resident is unable to be assessed for cognitive functioning or was uncooperative then there will be no score entered or 99 will be documented in the BIMS score box.

The facility Abuse Prevention Policy presented with effective date November 22, 2017,

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S9999	Continued From page 6 documented that residents have the right to be free from abuse) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act). Under abuse definitions the policy documented in part that abuse is willful, and it includes but not limited to verbal abuse and physical abuse. Physical abuse includes but not limited to hitting and verbal abuse includes that willfully includes use of oral disparaging and derogatory terms to residents or within their hearing distance. (B)	S9999		