| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145338 | A. Building<br>B. Wing | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oakwood Rehab and Nursing Center | 512 East Ogden Avenue<br>Westmont, IL 60559 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents received provisions of care and services required when a licensed nurse left the assigned unit resulting in lack of consistent nursing supervision and nursing care. This failure directly affected 3 residents (R2, R3 and R7.)The findings include:1.R2 was admitted to the facility on [DATE], with multiple diagnoses including congestive heart failure, asthma, morbid obesity, type II diabetes, anemia, hyperlipidemia, bipolar disorder, anxiety, hypertension, left wrist pain, cellulitis, chronic kidney disease, insomnia, gout, depression, hypoglycemia, depression, hypoxemia. R2's minimum data set (MDS) dated [DATE], showed R2 was cognitively intact.On April 20, 2026, at 10:30 AM, R2 said that on April 04, 2026 at 11:45 PM, R2 hit the nurse call button for anxiety medication. R2 said that V14 (CNA/Certified Nursing Assistant) came into the room and R2 asked V14 to get V18 (LPN/ Licensed Practical Nurse). R2 came back sometime later and told R2 she was unsure of where V18 was but would let her know as soon as she saw her. Sometime after midnight V15 (LPN) came down to the first floor to assist R2. R2 said at 1:45AM, V18 was still missing from the unit. R2 said that she looked outside of the window and observed V18 asleep in the car with the headlights on. R2 said several other residents had been looking for V18 throughout the night so R2 called the nonemergency line for the local police department. R2 said she looked out the window as an officer pulled into the parking lot. R2 said that she watched as the officer walked up to the car and shined a light through the car. R2 said it took a minute to get V18's attention. V18 turned the car off a few minutes later and returned to the facility. R2 said that she went into the hall and a few minutes later she observed the paramedics coming into the community and going down the hall to R3's room. R2 said that V18 then walked over to the med cart. The paramedics informed V18 that a male resident called 911 and stated that they were on the floor and could not find the nurse. R2 said V18 left the floor again at 5:00 AM to go buy coffee. R2 said that she informed staff the next morning and was told that a grievance was put in place and that V2 (DON) would follow up with her. R2 said a week went by and she had not heard from V2 so R2 reported the situation again. R2 said V2 entered her room asking what is it that she wanted to know. R2 informed V2 that she wanted to know about the follow up on the grievance that was submitted. R2 said that V2 told R2 the nurse was sent home the next day but that R2's story did not align with the CNA's that worked that night and no other residents had an issue. R2 said that there has been many issues and concerns with V18 and that V18 is not allowed to give R2 medications because V18 gave R2 the wrong medications once before. R2 said they do not discipline V18 they just take V18 off the schedule a day or two then hide V18 on a different unit. 2. R3 was admitted to the facility on [DATE] and discharged on April 09, 2025. R3 has multiple diagnoses including chronic obstructive pulmonary disease, asthma, congestive heart failure, hyperlipidemia, cerebral infarction, hemiplegia, hemiparesis, hypertension, bipolar disorder, benign prostatic hyperplasia, depression, anxiety disorder, constipation, pain, pulmonary embolism, medication noncompliance.R3's care plan showed R3 has difficulty breathing with exertion at night and is unable to lie flat due to shortness of breath. R3 prefers to sleep on his sides. Staff should give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. Head of bed elevated or out of bed upright in a<br>(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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | chair during episodes of difficulty breathing. 3. R7 was admitted to the facility on [DATE] with multiple diagnoses including heart failure, asthma, respiratory failure, convulsions, morbid obesity, anxiety, hypertension, sleep apnea, hyperkalemia, anemia, migraine, chronic pain, lymphedema, and major depressive disorder.R7's MDS showed R7 is cognitively intact. R7 said that she was asleep during the events of April 04, 2026 but said she had heard about it from several residents. R7 said that V18 is not allowed to administer medications to R7 due to V18 refusing to administer R7 their pain medications once before. On April 21, 2026, at 10:00 AM V14 said that they were working on the overnight shift on April 04, 2026. V14 said that on April 04, 2026, V18 left the floor for several hours and was unable to be found.V14 said that both V15 (LPN) and V16 (CNA) attempted to call and text V18 several times without response. V14 said that V18 gave V15 their phone number previously and told V15 to call if someone needed something. V18 was eventually found sleeping in their car. R2 called the police to inform them that the nurse could not be found, and several residents needed assistance. V14 said that she saw the police flash their lights into the window of V18's car. V18 rolled the window down and the police officer spoke to her and then left. The initial officer did not come into the facility. V18 came in a little bit after. Around 2:00 AM the paramedics came in and said they were there for a male resident who said they were not being assisted by the nurse and had fallen on the floor. V18 was unaware of what was going on and attempted to tell the paramedics that the gentleman was crazy. The paramedic and police stated that they still had to check and did a room check of the entire building. V14 said this was not the first time V18 had left the floor for several hours. V14 said during V18's time away R3 was anxious and having breathing problems. V14 said that they had also told V18 at the beginning of the shift that a resident needed a wound dressing changed. V18 did not change the dressing and the resident continued to call throughout the night while V18 was in the car. V14 said R2 was having anxiety and so V14 had to go to the second floor to ask V15 to assist. V14 said a statement was submitted to human resources and the DON but no one responded to them. V14 said that V18's practices are unsafe for the CNA's and nurses. On April 20, 2026 at 11:00 AM, review of grievances and employee files did not show any concerns or disciplinary actions regarding the events on April 04, 2026. V1 (Administrator) and V2 (Director of Nursing) both confirmed that all disciplinary actions and corrections were located in employee files. V18's file did not have any coaching or corrective actions inside. Progress notes entered by V18 and V15 showed V18 went on break at 12:00AM and was met by an officer at 12:20AM. However, review of the police report for the wellbeing check showed that officers were dispatched at 1:55AM. One officer arrived at 1:55 AM and another arrived at 1:58AM.On April 20, 2026, at 12:00 PM, V2 said that she was aware of the incident on April 04, 2026. V2 said that R2 has an issue with V18. V2 said that V18 went on break around 12:00 PM or 12:30 PM and was not gone that long before the police came. V2 said that R2 showed V2 the police call sheet. V2 said there is a discrepancy on the timing of the police report because it does not line up with what V14 and V15 informed her. V2 said she did not talk to any other residents except for the resident who called the paramedics to determine why the call was made. V2 said she did not review camera footage because V2 did not have access to the camera's footage. V2 said there were at least two residents on the first floor that V18 is not supposed to pass medications to. Investigation notes and interviews were requested for the incident at 12:00 PM. V2 said all documentation is in the employee files and stated she was going to grab the reports. A report was submitted at 3:08 PM that showed V18 received coaching on break times with V18 and V15's progress notes attached to it. The coaching was not signed by V18. There were no additional staff or resident interviews submitted and V14's report was not submitted either. V2 said that there had been previous grievances against V18 from residents that do not like V18. There was nothing in V18's employee file regarding the grievances mentioned. On April 21, 2026, at 12:16 PM V15 said that she was told by V14 that V18 had left the unit and R2 was requesting medicine. V15 said this was around 12:30PM and then V15 went back upstairs to manage the second floor. V15 said she did not see what time V18 came back into the building. V15 said when she came back down to the first floor at 2:00AM, V18 was in the building and (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was standing at the nurse's cart. V15 said she did not see the police and paramedics enter the building. They were talking to R2 when V15 came downstairs. V15 said she is not involved in the suspension of staff members. Review of the nurse's schedule showed V18 on shift as of April 10, 2026 working on different units. |