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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145714	A. Building B. Wing	05/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Park Oasis	625 North Harlem Oak Park, IL 60302

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 - Minimal harm or potential for 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** 41639 Based on interview and record review, the facility failed to prevent a verbal argument from escalating to a resident to resident physical assault. This affected two of three residents (R1, R2) reviewed for resident to resident abuse in the sample of 8. The findings include: R1 and R2 were discharged to the local hospital on 5/22/24 and have not returned to the facility. R1's electronic face sheet printed on 5/26/24 showed R1 has diagnoses including but not limited to dementia without behaviors, history of transient ischemic attack, depression, and heart disease. R1's facility assessment dated [DATE] showed R1 has moderate cognitive impairment, delusions, and wandering behaviors. R1's care plan dated 5/14/24 showed, Risk for increasing confusion related to diagnosis of dementia . R1's nursing progress notes dated 5/21/24 showed, Resident observed laying on the floor in the hallway. Resident stated, 'She pushed me'. Writer and another staff member assisted resident off the floor and walker her to her room. Full body assessment complete. No bruises or open areas noted to body at this time . Physician notified and order to send to (local hospital) for further evaluation .When she came back from the hospital had aggressive behaviors toward staff and residents used a lot of profanity threatened staff, seeing things that were false. Wandering around the unit made attempt to get on the elevator and when staff intervened she tried to hit them with her fist .Resident returned from hospital with no findings; however, psych physician made aware of aggressive behaviors and ordered to send to (local hospital) for psych evaluation R1's nursing progress notes from 5/10/24-5/22/24 showed R1 had 14 episodes of behaviors consisting of verbal outbursts, threatening residents, rummaging through other resident's rooms, threatening staff members, delusions, and verbal altercations with another resident. R1's progress notes showed other residents were becoming anxious, unable to sleep, and disturbed by her behaviors. R2's facility assessment dated [DATE] showed R2 has moderate cognitive impairment and behaviors not directed towards others. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/26/2024
NAME OF PROVIDER OR SUPPLIER Oak Park Oasis		STREET ADDRESS, CITY, STATE, ZIP CODE 625 North Harlem Oak Park, IL 60302	

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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 - Few	The facility's document titled, Final Abuse Incident Investigation Report Form showed, Date of alleged incident: 5/21/24. Physical abuse UNSUBSTANTIATED. (R1) alert and oriented x 2 with periods of confusion and forgetfulness, able to make her needs known .requires no assistance to ambulate. Her care plan was reviewed with a history of compromised decision making, roaming or pacing, becoming agitated, oppositional, and combative when re-directed by staff, displays conflictual, difficult behavior with other persons related to Dementia .(R2) alert x 1-2, able to verbalize herself with periods of confusion. She requires assistance with activities of daily living. Her care plan was reviewed with a history of pacing/roaming, displays conflictual, difficult behavior with other persons relate to dementia .Upon further investigation the following was found: On Tuesday, May 21, 2024 at approximately 1:15PM, (R2) went into her room and closed the door behind her. (R1) opened her co-peer's door. The two began arguing and calling each other names. (R2) pushed (R1) causing her to fall backwards. Staff immediately separated the two residents .The facility attributes the illness of both residents for their actions sites no findings of willful or intentional physical abuse . On 5/26/24 at 1:26PM, V6 (Certified Nursing Assistant) stated, (R1) and (R2) have been constantly arguing back and forth for a while now. They used to share a room but they couldn't get along so they separated them. They were still only about one room apart so they saw each other all the time. On 5/21/24, (R1) kept trying to get into (R2's) room and (R2) was pushing the door back on (R1) so she couldn't get in. (R2) then pushed (R1) onto the floor because she was sick of her trying to get into her room. I was the only person who saw the whole thing. I didn't get in between them when they were arguing because I didn't really know what was going to happen. It happened kind of fast. On 5/26/24 at 3:12PM, V2 (Director of Nursing) stated, I'm not sure what happened between (R1) and (R2). I don't do the abuse investigations. All I was told was (R1) kept trying to get into (R2's) room and then (R1) ended up on the floor. It's hard to say if it was abuse because they both have dementia. I think (R2) was just acting out and it got out of hand. On 5/26/24 at 3:25PM, V1 (Administrator) stated, I am the abuse coordinator for the facility and I handle all of the abuse investigations. In this particular incident, (R2) went into her room, closed the door, and then (R1) attempted to go into her room behind her. (R2) got upset and pushed (R1) down to the ground. (V6) was the only witness to this incident. This is not considered abuse because it wasn't willful or intentional. They both have symptoms of impulsivity and they can't control themselves. You and I could get into an argument and walk away but they don't understand how to do that. It's not okay that this is occurring but they both have dementia. A willful action would be a resident with dementia saying they are going to push someone and then they do. This was not the case in this situation. Neither resident knew what they were doing so it's not abuse. The facility's policy titled, Abuse Prevention Program dated 6/7/13 showed, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents .Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish .