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	11/14/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40987 Based on interview and record review, the facility failed to follow their abuse and injury of unknown origin policy by not initiating and completing a thorough investigation of an injury of unknown origin reported to the facility by a resident's family member. This failure applied to one (R1) of three residents reviewed for injury of unknown origin investigations. Findings include: R1 is [AGE] years of age. Current diagnoses include but are not limited to: Cerebrovascular Disease and Dementia Behavioral Disturbance. R1's MDS Minimum Data Set (Comprehensive Assessment) section C cognitive status dated 10/4/2024 documents a staff assessment indicating R1 being moderately impaired-decisions poor; cues/supervision required. R1 was admitted to the facility on [DATE] for respite care and was discharged home with family on 10/4/24. On 11/13/24 at 11:08 AM, interview with V4 LPN Licensed Practical Nurse regarding R1's bruising concern. V4 said, The lady family member said it was something on her arm, it was a bruise that wasn't there before. I didn't get anything in report about it. I called V2 DON down to speak to her family. The family was changing her clothes. The family called me in the room and the bruise was on her left forearm, but it didn't look fresh. She was only here four days, and I didn't get any report that she had an incident or anything. The family was really upset. The family pulled up R1's arm of her shirt to show me the bruise then immediately pulled it down. The family member told me to go get my boss. When V2 came she went into the room with the family, I stayed outside. V2 didn't say anything to me about the bruise when she came out the room. This was my first time taking care of her. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 11:45 AM, interview with V2 DON Director of Nursing regarding R1's bruising concern. V2 said, R1 was here a short time. She was a very feisty lady. She required a lot of monitoring and didn't sleep much. She required a lot of redirection. At times when trying to redirect her she would push you off her or it would take a minute to try to redirect her. Sometimes she would need more Spanish speaking staff to work with her, that's what she preferred. She wasn't very vocal. She had dementia. These are some typical things I'd see with it. When I was called to the room her family was here to pick her up. She said R1 had some discoloration to her arms, I don't remember which one. It looked like a thumb print on the upper arm. The area was maroon in color and when touched R1 didn't grimace or anything. It was about thumb or quarter size, about two sites. I just assessed the area. There was no swelling or pain. I looked at her medications to see if she was on any anticoagulants. I spoke to the family and explained to her R1 was very fragile and that we had to redirect her. The family said R1 didn't come here like that then she quickly took R1 out. I let the nurse know, V4 LPN. I asked the niece what she wanted us to do, and she took pictures. She said she would take R1 home and would follow up with her sister and call me back. The family did call me back but didn't say what she wanted to do with it. I asked V4 if he saw the bruise before, and he said he didn't. I looked at the admission charting and there was nothing observed stating she had any bruising. I asked the CNA (Certified Nurse Assistant); I don't remember who. I asked if she observed R1's bruise, she said no. I also asked the aide that was there 3pm-11pm and 11pm-7am shift but no one saw anything or how it got there. I have documentation of my own. I left it alone because the family never contacted me again. I don't know what else I needed to do. I don't have an investigation. Only from the people that I interviewed. The administrator should have been made aware. It should have been done for an injury of unknown origin. On 11/13/24 at 12:44 PM, interview with V5 CNA Certified Nurse Assistant regarding R1's bruising concern. V5 said, R1 was here for respite care. I work first shift. I never noticed any bruising, if so, I'd report it to the nurse. On 11/13/24 at 1:08 PM, interview with V6 CNA Certified Nurse Assistant regarding R1's bruising concern. V6 said, I took care of her the first day she came in. She was feisty and moved quick. She'd snatch herself away if we tried to touch her when redirecting her. I didn't give her a shower; I only had her two days. The last time I saw her she was sitting on her bed with her shirt off. She didn't have any bruises. My coworker and I helped her get a shirt on. On 11/13/24 at 1:32 PM, interview with V7 CNA regarding R1's bruising concern. V7 said, R1's niece came to take her home. She showed me her arm it had a bruise, but it looked old. She had a quarter size bruise on her arm, I can't remember which one. It was purplish dark, like it was getting old. She was combative. I didn't shower her when she was here. On 11/13/24 at 3:14 PM, Interview with V10 LPN regarding R1's bruising concern. V10 said, I work night shift. I can't recall any bruising on her. We don't do showers on our shift. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 9:42 AM, interview with V1 Administrator regarding R1's bruising concern. V1 stated, V2 DON was our assistant director of nursing and has been our director of nursing for the last two years. V2 has been trained on the abuse policy back in June of this year. V1 acknowledged any injury of unknown origin is in the abuse policy. V1 stated, I am the abuse coordinator. Any injury of unknown origin we would try to find out the source or how it happened and determine if there is suspicion of abuse. If we suspect abuse, we would conduct an investigation. V2 DON if it was brought to her, she should have let me know. We would take a look at it and decide if we needed to investigate. And we would follow up with the family. On 11/14/24 at 10:30 AM, Interview with V17 LPN regarding R1's concerns. V17 stated, I'm familiar with R1. Nobody told me about any bruising. I checked whatever was exposed for her. I didn't see anything abnormal or discolorations. Review of R1's records indicate shower sheets from Monday September 30, 2024, which was given by V9 CNA on the 3PM to 11PM shift. There are no skin issues documented on the shower sheet. R1 was also scheduled for Thursday October 3, 2024, 3PM to 11PM shift. The shower sheet indicates R1 refused and V4 LPN documented R1 had no skin issues. V2 DON was inquired of V4 lack of documentation regarding R1 refusing to shower on Thursday October 3, 2024, 3PM to 11PM shift. V2 said, V4 should have documented if R1 refused her shower. V2 provided typed interviews from other staff all who did not have knowledge of R1's bruising to the arm. R1's care plan states in part: resident is at increased risk for alteration in skin integrity related to impaired cognition. Interventions: skin will be checked during routine care on a daily basis and during weekly/bi-weekly bath or shower schedule. Any skin integrity issues/concerns will be conveyed to the Charge Nurse for further evaluation and/or treatment changes/new interventions and the medical doctor will be called PRN (as needed). Skin review form will be completed on admission and PRN for any new skin integrity issues. R1's admission screen dated 9/30/24 by V13 Registered Nurse states in part C. skin integrity 10. Does the resident have impaired skin integrity upon admission. 2. No. R1's discharge instructions do not document the family member's concern with bruising found on R1 prior to her being discharged . This form was signed by V2 DON Director of Nursing on 10/4/2024. There is no incident report or documentation in R1's medical record acknowledging R1's bruise found by her family member from V2 DON or nursing staff. V1 Administrator provided abuse prevention policy training dated 6/6/2024 which indicates V2 DON received training. The revised 9/9/14 Investigation of Injuries of Unknown Origin states in part: Policy: To promptly investigate resident injuries of unknown origin. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. All staff is responsible for prompt identification and reporting resident injuries to the nurse. 2. The nurse will immediately evaluate the resident and provide any needed intervention. 3. Descriptions of the injury, resident status, intervention, and any relevant observations will be documented. 4. Any needed referrals will be initiated by the nurse. 5. Any allegations/suspicions of abuse or neglect will be immediately reported to the DON and Administrator. 6. The DON (Director of Nursing) will notify the Administrator of the injury. Abuse investigation/reporting policies/procedures will be initiated any time an allegation or suspicion of abuse/neglect is involved. 7. The resident's care plan will be developed and/or updated accordingly. 8. An accident/incident report is completed. 9. An analysis of the circumstances is made and an attempt to establish a cause of injury and discussed at safety meetings. The Abuse Prevention Program Facility Policy states in part: Policy: 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 resident 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. This will be done by establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment; implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making the necessary changes to prevent future occurrences; and filing accurate and timely investigative reports. II. Identification and Internal Reporting A. Identification. The direct care staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor, administrator, or designated individual. Following the discovery of any suspicious bruises, lacerations or other abnormalities of an unknown origin, a nurse shall complete a full assessment of the resident for other bruises, lacerations, or pain. Documentation in the resident's chart should reflect the resident's physical and emotional status as well as any medical and nursing interventions implemented. (continued on next page)

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