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	01/07/2025

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** 39340 Based on interview and record review, the facility failed to follow their abuse policy by not preventing a resident to resident physical assault. This affected two of three residents (R1, R2) both reviewed for physical abuse. This failure resulted in R1 being punched in the face and being transferred to the local hospital for evaluation Findings include: R1 was admitted to the facility on [DATE] with a diagnosis of heart failure, dementia, schizophrenia, depression and auditory hallucinations. R1's brief interview for mental status score dated 11/8/24 documents score 10/15 which indicates moderate cognitive impairment. On 12/31/24 at 2:22PM, R1 who was alert and oriented was asked if he recalls the incident with his roommate. R1 said yes. R1 said there was something wrong with the toilet in his room that it wasn't flushing. R1 said R2 punched him in the face two times. R1 was unsure where it happened or why. R1 unable to recall if he went into bathroom with R2. R1 does not recall any injury or any other details. On 12/31/24 at 2:52PM, V6 (nurse) said she witnessed R2 punching R1 in the face in the hallway. V6 said she immediately went and separated the residents. R2 was upset about something in the bathroom. R2 had hit R1 a couple times in the face. R1 did not hit R2 back. R1 face was red but does not recall any injury. R2's progress note dated 12/10/24 documents: Writer went to the hallway area and stopped R2 from hitting resident R1 more. Alert and oriented x3. Resident very aggressive and angry and constantly hitting R1. Facility final abuse report form dated 12/10/24 documents: R2 was using the bathroom, his roommate R1 kept opening bathroom door. R2 exited bathroom and hits R1 in the face below right eye. Staff immediately separate residents. R2 was asked what happened and said R1 keeps messing with him by opening the door while using the bathroom. Both residents assessed for injury with R1 having swelling below right eye and redness to right eye. R2 has diagnosis of hunting's disease and violent behavior. Symptoms include mental confusion, compulsive behaviors, irritability, lack of restraint, anxiety, mood swings as evident by resident becoming irritable and acting impulsively towards his roommate. (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 01/07/2025
NAME OF PROVIDER OR SUPPLIER: Oak Park Oasis		STREET ADDRESS, CITY, STATE, ZIP CODE: 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	R1's hospital record dated 12/10/24 documents eye pain/injury for reported assault. Facility abuse prevention program policy undated documents: the facility affirms the right for our residents to be free from abuse, neglect, misappropriation of property, corporal punishment, and involuntary seclusion. The facility therefore prohibits the 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 occurrence of mistreatment, abuse or neglect by: implementing systems to investigate all reports promptly and making the necessary changes to prevent further occurrences; identifying occurrences and patterns of mistreatment; establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching and kicking.

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 01/07/2025
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to develop a plan of care for a resident with a history of violent behavior. This affected one of three residents (R2) reviewed for care plans. Findings include: R2 was admitted on [DATE] with a diagnosis of Huntington's disease, violent behavior, brief psychotic disorder and schizoaffective disorder. R2's brief interview for mental status score dated 12/2/24 documents score 14/15 which indicates cognitively intact. R2's progress note dated 10/11/24 documents: altercation with roommate. Staff attempting to separate, both residents punching at each other but hitting staff. Spitting at each other. R2 held other resident by the neck. R2 was sent to the hospital via petition. R2's petition dated 10/11/24 documents: R2 physically aggressive towards roommate, fighting and throwing punches to the roommate but punches landed on staff nurse, held his roommate's neck. R2's hospital record dated 10/11/24 documents: R2 admitted for aggressive behaviors of choking roommate. Per petition, R2 was agitated by roommate and choked and tried to punch roommate. R2's progress note dated 12/10/24 documents: Writer went to the hallway area and stopped R2 from hitting resident R1 more. Alert and oriented x3. Resident very aggressive and angry and constantly hitting R1. R2's progress note dated 12/30/24 documents: Resident exhibited aggressive behavior by striking and punching roommate. when approached, he stated, he keeps messing with me. R2's plan of care reviewed with no intervention documented for behaviors or resident to resident altercations and confirmed with V1(Administrator) and V2(Director of nursing,DON) On 1/3/25 at 2:28Pm, V2(Director of nursing, DON) said R2 had a care plan for mood or behaviors. V2 said social service is responsible for resident behavior care plans. After a resident-to-resident altercation, a new intervention should be put in place and monitored by staff. V2 was unable to locate any documentation of interventions for R2 after altercations or behaviors. On 1/3/25 3:37PM, V1 (Administrator) said they were unable to locate any plan of care or documented interventions for R2 behaviors and altercations. Facility care plan policy undated documents: all residents will have a comprehensive assessment and an individualized plan of care developed to assist them in achieving and maintaining their optimal status.