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	05/28/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45316 Based on interview and record review, the facility failed to follow their policy to conduct a contraband search on one (R1) of three residents reviewed for contraband possession. This failure resulted in R1 falling and hospitalized with a diagnosis of opioid overdose, and laceration of right eyebrow. Finding include: On 5/28/2025 at 11:52 AM, V3 (LPN) said that R1 did not fall on V3 shift. V3 said R1 is alert and oriented and makes his needs known. V3 said that R1 has a pass to go with relatives. V3 said that R1 went out with relative today about 8:30 am and was expected to be back to the facility around 2:00 PM. V3 said that the social service told V3 that R1 must be checked by the social service before R1 can get back into R1's room. V3 said that the social services are responsible for checking the residents before the residents return to their rooms. On 5/28/2025 at 12:04 PM, V4 (LPN) said that when V4 initially rounded on R1, R1 was alert and oriented and conversing. V4 said about less than ten minutes while V4 was walking the hall, V4 saw R1 on the floor in another resident's room. V4 called out to V2 (Director of Nursing) for help. V4 assessed the resident, V4 said that R1 was unresponsive, and 911 was called to transport to ER. (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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/28/2025 at 12:58 PM, V5 (Director of Social Services) said that R1 has never been out by himself. V5 said R1 is always accompanied by a family and friends. V5 said that R1's family comes and takes R1 out. V5 said that if R1 has not had any visitor to stay with him in the facility, but if he does have a visitor who wants to spend time with him in the facility, V5 said that the visitation will happen in the day room and monitored by the staff. V5 said that V5 was informed that R1 was unresponsive and was sent out to the hospital. Prior to 5/19/2025 incident, V5 said on 4/14/25 V5 observed R1 who appeared to be asleep, upon entering the room and getting closer R1, V5 observed a rolled-up dollar in R1's hand. V5 said that R1 was breathing, V5 shouted out R1's name and received no response. V5 said V5 notified the nurse and V5 removed the dollar from R1's hand, unrolled it and notice a white powdery substance on the dollar. V5 said that R1 was aroused and asked to identify the substance on the dollar in-which R1 refused to do so. V5 said that R1 was asked the question if there was any more of this white powdery substance in R1's possession and R1 stated I don't know what you are talking about. V5 said that R1's living area was searched and there was no contraband found. V5 said that after the incident, R1 was only allowed to go out with responsible party. V5 said that R1's belongings were supposed to be searched upon return from outing. V5 said that social services are supposed to search R1 belongings when he returns from outing. V5 said that V5 was not in the facility when R1 went out on pass on 5/19/2025. V5 said that V5 was not made aware that R1 was back into the facility. V5 said that V5 is not sure if any social worker searched R1 belongings when he returned from pass. On 5/2 /2025 at 2:17 PM, V2 (Director of Nursing) said that V2 was called down to R1's room in April because resident was sitting in the chair and nodding. V2 said that V1 and V5 informed V2 that a dollar rolled up with white substance was found in R1's hand. V2 said that V2 gave R1 a sternal rub which woke R1 up but R1 continue to go in and out. V2 said that after the incident occurred, R1 was moved to a room closer to the nurses' station so that R1 will be monitored more closely. V2 said R1 was made aware that R1 will have supervised visit only. V2 said that R1's emergency contact was notified that R1 can only have supervised visit. V2 said that R1 also notified that he can only go out with his emergency contact. V2 said that social services are also supposed to search R1 when he returns from the community outing. V2 said that on 5/19/2025, V4 (LPN) came to V2 to talk about R1 staying in another resident's room more frequently than usual. V2 said that V2 came down with V4 to go talk to R1. V2 said that R1 was observed on the floor with face down. V2 said that V2 observed small amount of blood on the floor. V2 said that R1 was unresponsive but was breathing. V2 said that V2 perform sternal rub, V2 said that V2 placed a pillow underneath R1 head and log rolled R1 to observe where R1 was bleeding from. V2 said that R1 was administered with Narcan and 911 was called. V2 said that V2 notified V1 (Administrator), and R1 nephew was called by (V1) to determine if he at any point left R1 alone. V2 said that R1's nephew admitted leaving R1 alone in the car for few minutes while he went to reactivate his phone. V2 said that V1 searched R1 pocket before the ambulance transported him to ER and found a bag of white substance in R1's pocket. V2 said that V2 called the cooperate office and notify them and also notified the IDPH. V2 said that the social service should have searched R1 when R1 returned from outing to the facility. V2 said that the social services failed in that area for not searching R1. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/28/2025 at 3:12 PM, V1 (Administrator) said that V1 was aware of R1 drug abuse incident in April. V1 said R1 was unresponsive, and the facility tried to wake him up and after shaking R1, R1 finally woke up. V1 said that R1 was placed on a pass restriction where R1 was only allowed to go out on pass with his nephew, and random room search to be conducted on him. V1 said that social service will search R1 when he returns from outing. V1 said that on 5/19/2025, R1 went out with his nephew. V1 said that R1's nephew assured the facility that he will keep a close watch on R1. V1 said that it wouldn't have hurt for the social service to search R1 when R1 returned from the outing with the nephew. V1 said that after the incident happened, V1 said that V1 called R1 nephew to ask if R1 was left alone at any time during his outing. V1 said that R1's nephew said that he left R1 alone in the car while he went to a phone store. V1 said that V1 found a packet of white powder in R1 pocket. R1 is a [AGE] year-old-male admitted on [DATE]. The social service note dated 4/16/2025, indicated that R1 was found unresponsive on 4/14/2025 and a dollar found in R1's hand when unrolled had white powdery substance on the dollar. On 5/19/2025, it was documented that R1 was also found on the floor unresponsive, and when R1 pockets were searched by V1 (Administrator), a bag with white substance in the bag was found in the left pocket. 5/19/2025 nurses note indicated that R1 was transferred to the hospital by 911 attendees. It was also documented that R1 went out on a pass with his nephew earlier on 5/19/2025. R1 after hospital visit summary indicated that R1 admission diagnosis was Opioid overdose, accidental or unintentional, and laceration of right eyebrow. Facility Policy: Policy on Contraband Materials, Inspection of Rooms and Use of Recording Devices Introduction: This organization reserves the right to conduct inspections if there is reason to suspect/believe that a resident has contraband items/materials in his/her possession. Procedure 1. Residents may be asked to empty and show the content of their pockets at any time if reasonable suspicion exists. 2. Residents may be asked to reach into concealed (Clothing) areas and remove any items and place these items on a horizontal surface. Staff are instructed to have the resident hand items to the staff member or place the items on the horizontal surfaces.