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	08/14/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed the facility failed to follow their policy to provide Discharge Instructions and Medications to one resident (R1)upon her planned transfer from the facility to another skilled facility. This failure affected 1 of 3 residents reviewed for discharge/transfers.The findings include:R1 admitted to the facility on [DATE] and discharged to another facility on 8/9/25.On 8/13/25 at 12:06PM V3, Restorative Nurse, said R1 had a planned discharge, I was working the cart. V3 said R1's family came and got her. V3 said the Secretary at the front desk told them to speak with a nurse, but the family just took R1. V3 said they did not speak with me. V3 said only the secretary saw the family. At 12:54PM V3 said the admitting facility called me around 12:31PM on 8/9/25, V3 checked her phone for times. V3 said that is when I became aware R1 had left. V3 said they called when R1 arrived saying no medications were sent with R1. V3 said I faxed the paper work to the facility after they called. The family said they spoke with me, but then said I thought it was you. V3 said she didn't know when R1 left so no medication was sent or discharge instructions were given. V3 said she had see R1 sometime after 9:00AM on 8/925 when she administered medications. V3 said R1 was in her room with her suitcase. On 8/13/25 at 2:00PM V5, LPN, said when a resident is a planned discharge we review the discharge instructions and medications with them. We send them the instructions, medication list, and any referrals they might have with them.R1's progress notes dated 8/8/25 states R1 requested to be transferred to another facility. R1's family will transport. On 8/9/25 progress notes at 12:02PM states writer notified via phone that R1 arrived to accepting facility. Nurse did not speak to the family, medication did not go with R1 at the time she left the facility.A Transfer Discharge Report dated 8/8/25 was presented. R1 transferred to another nursing home. Medications are listed. A Discharge Planning Review dated 8/8/25 was presented stating will be returning to the facility she came from before facility.No document presented for R1 has a signature on the day of discharge. No Discharge Instructions with R1 or representative signature was presented.Facility Discharge/Transfer of Resident policy dated 11/18 states in part, purpose to provide safe departure from the facility period to provide for continuity of care and treatment. Provide additional health education or medication instruction information for resident or family as indicated. Have resident or sponsor signed personal inventory of effects form. Heat transfer form accurately and completely including vital signs. Assist resident into wheelchair and escort to vehicle if necessary or assist attendance with transport. Document discharge summary. Include notes on specific instructions given such as medications to resident and responsible parties.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observations, and record review the facility failed to ensure that resident floors are free from hazards. Water noted on the floor near door entry ways. Water was observed in a puddle with a white towel over it in R3's room entry way. This failure affected five residents (R3-R7) of 6 residents reviewed for safe environment.The findings include:On 8/13/25 at 10:45AM surveyor walked past R3's room and saw wet floor, towel on the floor near liquid, and no wet floor sign in the room. Air conditioning grill above the wet area near entry door. R3 sitting in her wheelchair in the room.On 8/13/25 at 10:47AM V1, CNA, said I have seen leaking from the ceiling in this room, R4's-R7's. V1 said I saw it a week or two ago. V1 said it was leaking a lot.On 8/13/25 at 10:55AM surveyor walked past R3's room, the floor remains wet with a towel over it. R3 sitting in the wheelchair. R3 pointed to the ceiling air conditioner grill when asked where the water was coming from. R3 said they know about it. It's been like this for a while. V8, ADON, was walking past in the hall and surveyor requested she call maintenance. V6, Administrator, arrived while V8 was placing a wet floor sign and drying the floor with the towel. V6 said maintenance has been working on this. V6 said sometimes the humidity makes it drip. While talking to V6 the grill dripped 2 drops. The water on the floor was approximately 3 floor tiles wide and long.On 8/13/25 at 11:10AM V2, Maintenance, said the air conditioner is working in R3's room making the condensation that is leaking to the floor. V2 said the pipe needs to be opened. V2 said yesterday the leaking was in room [ROOM NUMBER], above R3's room. V2 said I need to clean the main pipe out and put pressure in it, 2-3 times a year. V2 said last week I cleaned it out in the administration office and room [ROOM NUMBER] (currently empty). V2 said today the leak has been in R3's room for about 2 hours. V2 said I have only been working here about 6 weeks and when I asked, no one knew about the pipes needing to be cleaned. V2 said they told me they had not been doing this. V2 said I have been cleaning the pipes as the problems are reported. V2 said the pipes get build up in them and I need flush them with the air compressor. V2 said they get clogged, and the water has no where to go but to leak.On 8/13/25 at 2:03PM R6 said about a week ago the ceiling was leaking, (pointed to ac vent). The floor was getting wet. They had a bucket, but it was overflowing and full. No one was emptying it. The water was spilling onto the floor and it was slippery to walk past.R6 fall risk assessment was completed on 7/14/25 and he is identified at risk for falls due to his unsteady gait and medications.R6's care plan dated 1/25/24 states at risk for falls related to unsteady gait.On 8/13/25 at 2:07PM V9, LPN, said I have seen the dripping from there, indicating the ceiling grill in R6's room. V9 said the CNA and maintenance are in charge of emptying the water bucket. V9 said if there is water on the floor, the residents are at risk for falls. All the residents in that room (R4-R7) ambulate independently and are in and out of the room.On 8/14/25 at 11:56AM V3 said residents with unsteady gait can be ambulating independently. V3 said for all residents we ensure nothing on the floor, nothing in their path, like furniture, other residents, keep paths clear, and spills are supposed to be cleaned up right away. V3 said every week we do team rounding to make sure all rooms are clean and no hazards. V3 said everything in the facility is designed for safety. Census identifies R4-R7 residing in the same room with the leak.Review of work orders first floor on 7/16/25 123 room leaky from AC, please check. 7/11/25 122 room water dripping from the ceiling. [Illegible month] /8/25. 7/24/25 3:55AM room [ROOM NUMBER] ceiling by bathroom (vent) leaking causing huge puddle making hole in the wall bigger. Put something to catch it. 7/24/25 4:20AM room [ROOM NUMBER] leak by bathroom door and head od bed. Garbage bin catching leak now. Undated Rooms 203, 205, 207, and 206 leaking air conditioning condensation. On 8/8/25 room [ROOM NUMBER] water in middle of floor.The facility fall policy dated 2/28/14 states the standard fall safety precautions for all residents in part states the residents environment will be kept clear of clutter Which would affect ambulation and remove hazards.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed the facility failed to ensure staff followed the facility practice of nurses not leaving the unit at the end of a shift without a relief. This failure resulted in the unit not having a nurse on unit for at least 1 hour. This failure has the potential to affect 36 residents residing on the unit.The findings include:On 8/13/25 at 12:06PM V3, Restorative Nurse, said on the second floor there is normally 2 nurses, 1 on main unit and 1on pavilion unit. V3 said 8/9/25 there was a call off for day shift I was notified at 8:45AM that there was a missing nurse on 2 main. V3 said I took over the cart about 9:15AM. V3 said I found out because I was coming in as Manager on Duty. V3 said I didn't clock in or out that day. V3 said the off going nurse is supposed to wait until the next nurse comes in before leaving. V3 said V12, LPN, called in. V3 said when I got to the facility the staff told me there was no nurse on 2 main. V3 said the call ins go to the DON or ADON. V3 said the unit was without a nurse for about 2 hours. V3 said CNAs can't pass medications. V3 said I don't even know what time I finished the morning medication pass, we had a code, reports of an alleged smoking violation I had to look into, and the Manager on Duty responsibilities.On 8/13/25 at 1:59PM V7, CNA, said we are supposed to call in 4 hours before our shift. We call into the DON to notify her.On 8/13/25 at 2:00PM V5, LPN, said we give verbal report to the oncoming nurse and we do a narcotic count with them. V5 said we are not supposed to leave the shift without a relief.On 8/13/25 at 12:42PM V6, Administrator, said I was made aware when V3 notified me on 8/9/25 that there was not a nurse for the 2nd floor unit. V6 said V3 took the cart. V3 said calls offs are to go to the on call person and DON. V6 said it is not the facility practice for the nurses to leave before a relief arrives. On 8/14/25 at 9:50AM V6 said we are a skilled nursing facility, we provide nursing care 24 hours a day.On 8/14/25 at 8:02AM V10, LPN, said I was not told there was a call off for the morning of 8/9/25. I was not asked to stay over on 8/9/25.On 8/14/25 at 12:45PM V14, Director of Nursing, said V12 text me last minute on 8/9/25. V14 said it was 6:50something in the morning when she text. V14 said I didn't even hear the text, I didn't know V12 wasn't in the building until V3 notified me. V14 said if I had known, I would have come in and had the nurse wait for me. V14 said call off should be 4 hours before the shift, staff should call the on call number. V14 said this is told to them at hire and is in the handbook. At 12:57PM V14 presented the unit census for 8/9/25 and said the unit has 36 assigned residents for the nurse.Review of time cards includes 8/9/25 V11 clocked in at 7:33AM; V13, LPN, clocked in at 6:51AM; V9, LPN, clocked in at 6:59AM. V12 is designated absent on 8/9/25. V10 clocked out the morning of 8/9/25 at 7:32AM.Review of Controlled Substances Check Form dated 8/9/25 unit 2 Main has no day shift on nurse or off nurse signature.The facility attendance policy in part states it is an employee's responsibility to notify their supervisor promptly of their absence for any scheduled work day. Employees should call at least 4 hours in advance of their scheduled start times.The Facility assessment dated [DATE] identifies on day shift (1st shift) 4 nurses will provide direct care to the residents.