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	12/18/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow policy procedures, failed to document medication administration, failed to ensure prescribed medications were administered timely to three residents (R10, R37, R102) residing on 2nd floor in a sample of 25 residents. The facility further failed to ensure timely and appropriate emergency medical response and failed to follow facility's hypoglycemic protocol. These facility failures affected one (R116) of one resident reviewed for quality of care and resulted in R116 experiencing a blood sugar level of 40 (critical) and hospitalization requiring intensive care services. Findings include: R116 is a closed record. R116 was transferred to the hospital on [DATE]. R116's diagnoses include but are not limited to adult failure to thrive, chronic respiratory failure, dependence on supplemental oxygen, type 2 diabetes, hypertension, chronic obstructive pulmonary disease, malignant neoplasm of unspecified part of unspecified bronchus or lung, and obesity. R116's BIMS (brief interview mental status) score, dated 9/22/2025, is 13 which indicates R116 is cognitively intact. R116's physician order, ordered date 6/10/25, documents, in part, POLST: Attempt resuscitation/CPR (selecting CPR means intubation and mechanical ventilation). R116's progress note, per V23 (Registered Nurse), dated 10/19/25 at 6:11am, documents, in part, Writer entered room around 4:30 am. Resident (R116) would not respond to any verbal or physical stimuli. Writer called residents (R116) name loudly while shaking her shoulders, no response. Pupils dilated round and reactive to light assessed after raising eyelids. Mucus membranes moist. O2 NC 3LPM patent. Foley draining amber colored urine. Bowel sounds hypoactive. Lung sounds clear bilaterally. Compromised skin integrity, dryness, breakdown over arms, legs and perineal area. BP 132/64, P 65 T 95.4 O2 Sat 94% without 3L NC, 98% w/ 3L NC. BS 59 initially, Sugar given by mouth BS 63, Writer & Supervisor unable to get IV access for dextrose. 911 called around 4:50 am. MD (medical doctor) called no answer NP (nurse practitioner) called no answer. BS dropped down to 40 before EMS (emergency medical services) arrived. EMS arrived around 5:05 am, (R116) taken to hospital. R116's progress note, per V18 Licensed Practical Nurse/LPN), dated 10/19/25 at 1:27pm, documents, in part, Called (hospital) and spoke to with nurse in emergency department she (R116) is admitted in the ICU (intensive care unit), who then transferred me to ICU and spoke with nurse, she (R116) is still hypoglycemic and having some respiratory issues as well. (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 0684 Level of Harm - Actual harm Residents Affected - Few	R116's hospital records, admission date 10/19/25, documents, in part, Pt (R116) arrives via EMS (emergency medical services) from Nursing Home, pt (R116) was unresponsive on arrival in NH (nursing home) reported to have sugar of 50. Blood sugar 25 by EMS and given glucagon repeat 20. Not responsive on arrival. In the ED (emergency department), pt (R116) was initially hypothermic to 96.1F. Pt (R116) on 3L Nasal Cannula for COPD (chronic obstructive pulmonary disease). Initial labs were remarkable f glucose 42, Albumin 1.5, lactate 2.5 -> 3.8, WBC 14.95K. Arrived with foley placement, scant urine output, cloudy and clumpy output. Foley bag was noted to have grossly tenacious component. Foley leaking purulent urine malodorous. Her (R116) Foley catheter was exchanged that also had thick clumps debris and dark urine with concern for infectious etiology. Spoke to the patient's daughter and updated her in regards to her being at Rush Oak Park. She specifies that she would like her mother to be full code and receive chest compressions as well as intubation if she decompensates. During the ICU (intensive care unit) stay the patient (R116) was treated for ESBL (Extended-Spectrum Beta-Lactamase) bacteremia and UTI (urinary tract infection) with meropenem and MRSA bacteremia with vancomycin and pneumonia, as well as candida intertrigo with fluconazole. Patient mental status remained poor with severe pain given diffuse skin wounds. Patient family ultimately made a decision to make the patient DNR (Do Not Resuscitate) and today made a decision to transition the patient to inpatient hospice here in the unit. Presents with toxic metabolic encephalopathy. admitted with PNA (pneumonia) and Sepsis= 2/2 complicated UTI. See past medical history below. Extensive skin breakdown and? Abrasions present on admission-see photos. Moaning/crying throughout care. Four-eye skin assessment completed: under abdominal folds, breasts, back, bilateral outer and inner thighs, Left heel DTI and cracked and dry, sacrum, and perineal area. Report to IDPH (Illinoi Department of Public Health) for concerns of neglect from (nursing home) where patient has been a resident since June 10th, 2025. Pt appears un-cared for. Unbathed and skin was extremely dirty and dry. Back side reddened and with multiple areas of skin break down. Foley appears unchanged and extremely dirty. Sepsis--hypothermia, leukocytosis: Likely 2/2 R-sided PNA (pneumonia), suspect aspiration component; +/- component of GU infection, at risk given indwelling foley catheter though pyuria and mixed flora colonization expected. During the ICU stay the patient was treated for ESBL bacteremia and UTI with meropenem and MRSA bacteremia with vancomycin and pneumonia, as well as candida intertrigo with fluconazole. Patient family ultimately made a decision to make the patient DNR and today made a decision to transition the patient to inpatient hospice here in the unit. This patient has a high probability of sudden, clinically significant deterioration, which requires the highest level of physician preparedness to intervene urgently. R116's MAR (Medication Administration Record), dated October 2025, documents, in part Accu-Chek QID (4 times a day) AC & HS before meals and at bedtime for DMII (Diabetes Mellitus II). R116's care plan, dated 7/09/25, documents, in part, (R116) has diabetes mellitus & the potential for complications related to: Elevated blood sugar., History of uncontrolled diabetic status., The resident is: Insulin dependent, with interventions that document, in part, Assess for signs of hyperglycemia or hypoglycemia; Provide medication as ordered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/16/25 at 2:14pm, V23 (Registered Nurse/RN) stated, Yes, I was familiar with the patient (R116). During my rounds, the patient (R116) was found unresponsive. I was unable to obtain vital signs, and the patient's (R116) blood sugar was low. I attempted to administer dextrose but was unable to obtain IV (intravenous access). The patient (R116) was sent out. V40 (Registered Nurse/RN) tried to give R116 sugar in her (R116) mouth to bring up R116's blood sugar. The sugar was regular table sugar. R116 wasn't given a lot of sugar because the patient's (R116) mouth was not open. I am not sure why this method (oral table sugar to an unresponsive resident) was used, and I understand that administering anything orally to an unresponsive patient is unsafe due to the risk of choking. When a patient is unresponsive, the first action should be to call 911, and it should be done in a timely manner. The patient felt cold to the touch, and a temporal thermometer was used. I was a new nurse at the time and was doing my best to the best of my ability. I immediately called for help by contacting my supervisor to determine the next plan of action. On 12/17/25 at 10:46am, V40 (Medical Director) said, For an unresponsive resident, the resident should be sent to the hospital immediately. The first step is for another nurse to evaluate the resident, and another nurse call 911, and ensure the resident is transported to the emergency room without delay. Administering oral sugar to an unresponsive resident who cannot swallow is ineffective and should not be done. A Foley catheter not being changed routinely can increase the risk of developing a urinary tract infection if not properly managed. Sorry, I am not familiar with R116. On 12/17/25 at 11:18am, V2 (Director of Nursing/DON) said, R116 was in and out of the hospital. She (R116) came in June 2025), but I didn't start until September (2025). Before my time. Based on the documentation, she (R116) came in June (2025) with a Foley catheter. The Foley was never changed in-house and there is no documentation that she (R116) refused to have the foley changed. Not changing a foley can cause infection. I would need to review her (R116) notes for more details. On 12/17/25 at 12:05pm, V40 (Registered Nurse/RN) said, I was called V23 (Registered Nurse/RN) who stated that she (V23) went to do routine care and found her (R116) unresponsive. At that moment I knew she (R116) was diabetic and check sugar and tried placing sugar in her (R116) mouth. Checked her (R116) sugar and sugar went up but then came right back down. Yes, I tried putting in and IV (intravenous) in her (R116) and was unsuccessful. When a resident is unresponsive, you do an assessment and call a code immediately. Yes, Call 911 immediately, but I knew it was hypoglycemia, so we (V40 and V23) were trying to get sugar up. If glucagon was available I would have given it to her (R116). If I remember, I don't recall exactly, I usually call 911 from my cellphone. I don't recall exactly. I do agree that 911 should be called immediately. Oral sugar is not safe when a resident is unresponsive, but I placed the sugar in between her (R116) lips and gums, because time was of the essence, and we were trying to bring the sugar up. We do have glucagon in the emergency carts, but we just didn't have it (glucagon) that morning. All I know is I asked V23 for some glucagon and V23 said V23 didn't have none. Each emergency cart has glucagon, so I don't know why she (V23) said she (V23) have any. On 12/17/25 at 12:43pm, V2 (Director of Nursing/DON) said, Glucagon is in the emergency kit. Yes, glucagon is always available. It (glucagon) should be given for hypoglycemia. Glucagon should have been given for a blood sugar less than 60 if the resident was unresponsive. The 12/14/25 census includes 72 (2nd floor) residents. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/15/25 at 10:50am, twenty (20) residents were affirmed to be highlighted red (indicating late administration) on the (2nd floor) EMAR (Electronic Medication Administration Record). Surveyor inquired why 20 residents were highlighted red on the EMAR V6 (LPN/Licensed Practical Nurse) stated Its highlighted red cause it needs signed out. I (V6) have to sign the medications that I give as I give it out, it got kinda busy today. We (staff) normally sign em out as we go. 12 of em (residents) are mine. Surveyor inquired which residents did not receive their 9am medications V6 responded Everybody got they're 9am meds. Surveyor inquired whose medications were in the cup - that V6 was holding V6 replied (R10's name). On 12/15/25 at 11:11am, V6 administered R10's medications (scheduled for 9am administration) therefore not within regulatory requirements (within one hour; before or after the scheduled time). On 12/16/25 (the following day) at 9:41am, surveyor relayed that AM medication administration was being observed today V19 (LPN) stated I'm (V4) finished with my morning meds already. Surveyor inquired why R11's name was highlighted red on the EMAR V19 responded I (V19) just need to check her (R11) blood sugar before I give it. Surveyor inquired why R11's insulin (scheduled for 8am administration) was not administered V19 replied This is my second day working here. Surveyor inquired about the regulatory requirement for medication administration V19 stated An hour before and an hour after, so yes, I'm late to her (R11). On 12/16/25 at 10:01am, R37 and R102 were highlighted red on the 2nd floor EMAR. V6 affirmed that medications (scheduled for 9am administration) were not administered to R37 and R102 therefore late. The (8/15) medication administration policy states medications must be administered in accordance with a physician's order ant his/her discretion (the right resident, right medication, right dosage, right route, and right time). Documentation of medication administration is recorded on the MAR (Medication Administration Record) and includes the date, time and initials of the licensed nurse who administered the medication. Record review of facility policy titled, Hypoglycemia, dated 9/14, documents, in part, Nursing Intervention: Give some form of glucose if resident is conscious: Mild reaction -small amount of food 10-15 gm carbohydrates (such a 4 oz. orange juice 6 oz. regular soda, 8 oz. 2% skim milk) repeat in 10-15 minutes if needed. Moderate reaction (drowsy, profuse perspiration, blood glucose 30-50 below normal) 20-30 gm. Carbohydrate, 4 oz. orange juice followed by food in 10 – 15 minutes. May give orange juice instead of food if still symptomatic. Contact physician if blood sugar is below 60 unless there are specific call parameters. Take vital signs Repeat finger-stick fifteen (15) minutes after first item of food is given. If unable to swallow notify physician and prepare glucagon from emergency drug kit for administration as ordered. Prepare to send to emergency room if condition worsens per MD order. Document findings, interventions, and M.D. contact in resident's clinical record. Record review of facility document titled, (Name of Facility) (Medication Dispensing Cabinet) List, undated, documents, in part, Glucagon Emergency Kit 1mg powder for injection D-Utility drawer 16. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of facility policy titled, Change In Condition Physician Notification Overview Guidelines, dated 4/14, documents, in part, These guidelines were developed to ensure that: 1. All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and is to be documented in the medical record. 2.Medical care non-emergency problems are communicated to the attending physician and family in a timely, concise, and thorough manner (generally with twenty-four (24) hours or sooner). 3. Medical care emergency problems are communicated to attending physician and family immediately. The nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgment requires immediate medical intervention. Should the physician not be available, the alternate physician should be contacted. If neither of these physicians are available, the Medical Director should be notified. A. Any calls to or from physician will be documented in the nurse's notes indicating information conveyed and received. B. All orders taken from the physician, the Physician's Assistant or Nurse Practitioner to be carried out. C. The nurse receiving telephone verbal orders should write it on the POS. Acute and subacute problems are to be communicated shift-to-shift by verbal report and highlighting or discussing the problems listed on the 24 Hour Shift Report to facilitate communication and Quality Assessment and Improvement follow-up. E. The nurse shall indicate in the nurses notes ongoing conversations with the physician regarding response to notification(s) (faxes, phone calls, and verbal conversations) of changes in condition, laboratory. F. Responsible Party is to be notified of change in condition. The attending physician is responsible for responding in a timely manner to nurses regarding prompt notification calls, or emergencies. In addition, the physician is responsible for communicating the results of assessments and medical plans to a licensed nurse when appropriate. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually. Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.