STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145714	A. BUILDING _____ B. WING _____	**09/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and record review the facility failed to notify the physician and a resident's responsible party of an allegation of sexual abuse. This deficient practice affects one of seven residents (R1) reviewed for sexual abuse in a sample of seven. Findings Include: R1 is a [AGE] year old male originally admitted on [DATE] with medical [DIAGNOSES REDACTED]. According to V19 (Psychiatrist) note dated 11-22-2019 reads: R1 male with intellectual disability, alert and oriented to self only, communicates with gestures and grunting. According to progress notes dated 9/19/2019 at 15:28 reads; V8 (Licensed Practical Nurse) made aware by staff that it is suspected that R1 was having intercourse with another resident, administration made aware. On 9-8-2020 at 9:48am, V8 (LPN) said, I do not remember if I informed the Medical Doctor and the State Guardian, if I did I will make sure to document, but is not indicated in my note, I do not know if I called them or not. On 9-4-2020 at 11:45 am, V2 (Director of Nursing) said: my expectation is that the nursing staff will notify the family and state guardian when an incident happens, they need to know what is going on with the patient and the nurse needs to document in the patients chart. On 9-9-2020 at 1:30pm, V16 (Public Guardian) said, the facility did not report to us when the incident happened in 9-19-2019, R1 is not able to consent to have intercourse, he does not have the ability to make that decision due to his mental disability. On 9-8-2020 at 3:00pm, V2 (Director of Nursing) presented a policy titled Incident/Accident Reports, dated 9/14 reads: An Registered Nurse(RN) or Licensed Practical Nurse (LPN) must notify the following, physician, legal representative or interested family member within 24 hours
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to immediately report to Illinois Department of Public Health (IDPH) a sexual abuse allegation. This deficient practice affects one (R1) of seven residents reviewed for sexual abuse in a sample of seven. Findings Include: R1 is a [AGE] year old male originally admitted on [DATE] with medical [DIAGNOSES REDACTED]. Per V19 (Psychiatrist) note dated 11-22-2019 reads: R1 male with intellectual disability, alert and oriented to self only, communicates with gestures and grunting. According to progress notes dated 9/19/2019 15:28 reads; V8 (Licensed Practical Nurse) made aware by staff that it is suspected that R1 was having intercourse with another resident, administration made aware. On 9-8-2020 at 9:48am, V8 (LPN) said, I can see, I wrote the note but I do not remember who told me about it, I do not remember any specifics, I told the director of nursing or the assistant director of nursing, I do not remember exactly whom I reported it to. On 9-8-2020, V10 (Regional Supervisor) said, I remember investigating an allegation in December 20, 2019 and I read R1's progress notes for September 19, 2019 and I did not have any knowledge of that occurrence. It was not investigated nor reported to the Illinois Department of Public Health. V10 said, the facility expectation is that IDPH, the family and the doctor are inform when an incident happens. On 9-8-2020 at 3:00pm. V2 (Director of Nursing) presented a policy titled Incident/Accident Reports, dated 9/14 reads: abuse incidents must be reported to Illinois Department of Public Health within two hours of occurrence or immediately.
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** Based on observation , interview and document review the facility failed to implement intervention to protect a resident (R3) while an abuse investigation was being conducted and immediately make efforts to identify the person (R6) excused of sexually abusing R3. Also, the facility failed to conduct an investigation and report an allegation of sexual abuse involving R1. This facility involved three residents (R1, R3 and R6) of seven residents reviewed for sexual abuse. Finding includes: 1. On 9/5/20 the facility was currently conducting in an investigation of a sexual abuse allegation that was initiated on 9/4/20 between residents R3 and R6 . The facility initial Preliminary Abuse Incident Investigation Report Form dated 9/4/20 at 2:50PM states action taken including the following statements. The individual alleged to have committed the incident has been removed from resident contact and will remain so until a conclusion is reached concerning the allegation in order to prevent potential incidents while the investigation is in process. Information from the local hospital identified R6 as the person, R3 accused as the person who sexually assaulted him. On 9/5/20 at 10:30AM, R3's room was approached by surveyor. R6 was observed standing in the doorway of R3's room. R3 was inside his room. R3 on 9/5/20 10:25AM stated, I was sexually assaulted yesterday. I went to the hospital and they gave me a blue folder. I'm safe now. The person who did this is still walking around in the facility. I do not want to say who. I don't want to talk about what happened. 9/5/20 at 10:25AM, R6 stated I am buddies with R3. I see him in the hallway a lot. I say hi to him often. I have not had any problems or altercations with him. We get along. V12 (Nurse in charge of wing) 9/5/20 at 10:55AM, stated I am not aware of any incidents concerning R3. I do not know of any special instructions for R3. I did not know R3 was to be on any monitoring precautions. V15 (CNA responsible for R1's care) 9/5/20 at 10:45AM stated, I take care of R3. I do not know of any incident with R3. There are no special instructions communicated to me on duties to be performed. I did not know he was to be on monitoring status. V1 (Administrator) 9/5/20 at 11:05AM, stated R3 is in facility at this time. R3 is on precaution of assault protocol. R3 is supposed to be monitored while at the facility. R3 is in his own room without a room mate. The investigation into his assault is currently being investigated. R3 did not give a perpetrator. V1 (Administrator) 9/5/20 at 12:23PM stated R3 alleged abuse was relayed to me. I initiated the abuse investigation. I made sure R3 was in room by himself . R3 is normally in room by himself with no roommate. I told staff to perform ongoing monitoring to him until police came. Police did interview and made a report. We sent resident to hospital for observation and to perform rape kit. There has been no results from rape kit yet. He was readmitted to facility last night. I contacted staff to ensure ongoing monitoring and initiated investigation. We have staff in area assigned to a group of rooms to observe residents. I did start with staff statements. R3 was interviewed by social services director before he went out but he did not give a perpetrator. We do not have the perpetrator at this time. At this time he is to be monitored. Nothing else is being done at this time. I did not review any hospital report at this time. There are no other rape investigations going on at this time. Facility Abuse Prevention Program Facility Policy dated 6/7/20 includes the follow statement: Immediately protecting residents involved in identified reports of possible abuse. Implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making necessary changes to prevent further occurrences. 2. R1 is a [AGE] year old male originally admitted on [DATE] with medical [DIAGNOSES REDACTED]. According to V19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) (Psychiatrist) note dated 11-22-2019 reads: R1 male with intellectual disability, alert and oriented to self only, communicates with gestures and grunting. According to progress notes dated 9/19/2019 15:28 (3:28 PM), V8 (Licensed Practical Nurse) made aware by staff it was suspected that R1 was having intercourse with another resident, administration made aware. On 9-4-2020 at 11:45 am, V2 (Director of Nursing) said, Any allegations of sexual abuse need to be reported to Administrator and we need to start the investigation. The first thing is to ensure the safety of the residents, we will separate them immediately, we call the doctors, the family and we will monitor them during activities, during meals, at night time, frequent monitoring include 1:1, every 15 minutes or as determined based on the allegation. On 9-4-2020 at 3:10pm, V7 (Former Administrator) said I was not aware of any incidents involving R1 in September 19, 2019. .On 9-8-2020 at 9:48am, V8 said: I can see I wrote a note on 9-19-2019 but I do not remember who told me about it, I do not remember any specifics, I do not remember if an investigation was done, R1 was not sent to the hospital for evaluation. On 9-8-2020 at 1:20 pm, V10 (Regional Supervisor) said, I remember investigating an allegation in December 2019 and I read R1's notes for September 19, 2019 and I did not have any knowledge of that one, It was not investigated On 9-8-2020 at 3:00pm, V2 (Director of Nursing) presented an undated policy titled: Abuse Prevention Program, reads: This facility is committed to protecting our residents from abuse, employees are required to report any incident allegation or suspicion of potential abuse. All incidents will be documented, any incident or allegation involving abuse will result in an abuse investigation.