STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000816	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Rehab and Nursing Center	**512 EAST OGDEN AVENUE , WESTMONT, Illinois, 60559**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey	S0000		10/03/2025
S9999	Final Observations Statement of Licensure Findings: 1 of 2 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and	S9999		10/03/2025

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

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S9999	Continued from page 1 mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to supervise a resident who repeatedly wanders into the rooms of his peers. This failure resulted in startling a resident who was in bed for the night (R50), causing her to get up and fall, sustaining a fracture. The facility also failed to supervise the dining room during a resident meal, failed to secure an oxygen tank, and failed to use a full-body mechanical lift to assist a resident into bed. This applies to 12 residents (R50, R10, R36, R37, R19, R75, R78, R8, R3, R72, R41, and R91) reviewed supervision and safety. The findings include: 1. On 9/16/2025 at 10:50 AM, R10 said R91 came to her room at 4 AM at night and sat down. R10 said he sat in	S9999		

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S9999	Continued from page 2 her room for 30 minutes to an hour. R10 said she was "not happy." On 9/17/2025 at 10 AM, V13 (CNA) removed the white shirt R91 was wearing and brought it to R10 and said R91 thought it was his shirt and was sorry. R10 responded by saying “he takes the clothes and he’s sorry. He’s sorry every time. Nobody cares about this. He comes into my room and takes my pillow and steps on my pillow, and nobody cares. I want to go from here to another room.” On 9/17/2025 at 10:08 AM, R10 said when R91 came to her room at night, she was scared as it was the middle of the night. On 09/16/2025 at 11:01 AM, R91 wandered into R36 and R37’s room and stood by the doorway. R91 took the wheelchair out and was pushing it around. R91 lifted the cushion seat. During an interview with R10 on 09/16/2025 at 11:03 AM, R91 entered R10’s room. R10 asked R91 what he wanted and told him it wasn’t his room and she did not want him in there. At 11:06, AM R91 was still in R10’s room. No staff came around to see what he was doing. R10 told him to “go away” and said she “was going to call the police.” R91 just stood there and said his pants were falling down. R91 then took R10’s glasses off the table. R10 said "don't touch" and R91 put them down. R10 told R91 to “go away” but he stayed in her room. On 09/16/2025 at 11:09 AM, R91 left R10’s room and went into R36 and R37’s room. R91 touched the bed, incontinence pad, and sheets on one of the beds. R91 took the pillow out of the room and put it on a chair in the hallway. At 11:13 AM, R91 returned to R10’s room then left again at 11:14 AM. On 09/16/2025 at 11:23 AM, V6 LPN (Licensed Practical Nurse) walked to R10’s room and R91 was back in her room and V6 removed him. R91’s face sheet showed he was admitted to the facility on 9/12/2025 with diagnoses including dementia and insomnia. R91’s MDS (Minimum Data Set) dated 9/18/2025 showed R91 had severe cognitive impairment. R91’s Care Plan with an effective date of 9/15/2025 and initiated on 9/18/2025 (during the survey) showed R91 “displays compromised mental status and demonstrates some movement and verbal behavior consistent with elopement.” R91’s care plan did not identify R91’s wandering behaviors or contain interventions to keep R91 or other residents safe. R91’s progress note, written on 9/15/2025 at 12:37 AM by V11 (LPN), showed “Resident has been going around other residents’ rooms, taking things that don’t belong	S9999		

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S9999	Continued from page 3 to him. Resident went into female resident room (female resident sleeping soundly). Female resident was awakened from resident's noise. He was going through female resident's clothes. Took 3 staff to encourage resident to leave female resident's room. [Medical Doctor/MD] made aware of resident's behavior. He hasn't had any sleep since admission. Resident requires 1:1 care. Very restless, non-compliant with instructions, no safety awareness whatsoever…" On 09/16/2025 at 3:16 PM, V11(LPN) said R91 was new to the facility. V11 said R91 wandered, went into other residents' rooms, and took things from their rooms. V11 said the staff do their best to supervise him but he needed someone with him at all times, as he was not safe on his own. V11 said the doctor was aware of the wandering behavior from when he was admitted. On 09/17/2025 at 2:08 PM, V11 said R50 had a fall on 9/14/2025 at around 8 PM and was sent to the ER for a closed displaced fracture of the left femoral neck. V11 said she was charting and R91 was walking around. V11 said she heard R50 screaming and went in there and saw R91 standing next to her bed by the closet. V11 said R50 told her she was asleep and woke up and saw R91 going through her closet, got startled, scared, jumped out of bed, and fell. V11 said R91 needed 1:1 monitoring, as he did not sleep. V11 said the memory care unit did not have enough staff to supervise R91. In R50's progress note from 09/14/2025 at 11:11 PM, V11 (LPN) wrote: "Heard resident screaming in her room around 8pm. Upon entering resident's room, observed resident on the floor next to her lowbed, on her left side…..bruising to left elbow and left hip area….Per resident statement," I was asleep and I was awakened by some noise in my closet. When I opened my eyes, I saw [R91's physical description] going through my clothes. I got scared. I jumped out of the bed to get away from him." Checked for injury, pain….[MD] made aware of the incident. Noted order to send resident to ER (Emergency Room) for eval and treat. DON (Director of Nursing) also made aware of the incident. Endorsed to incoming shift." R50's progress note from 9/15/2025 at 8:56 AM showed: "Resident was transferred to [Hospital]. …told that resident is admitted for closed displaced fracture of left femoral neck…" On 9/17/2025 at 10:06 AM, R91 was again in R36 and R37's room. On 09/17/2025 at 2:36 PM, R91 was in R36 and R37's room with the door closed. No other residents were in the room. He came out and said "I think I got the wrong room" and went into R10's room and closed the door,	S9999		

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S9999	Continued from page 4 then opened it again and left. Three minutes later, R91 returned to R10's room and started touching R10's blankets and pillows and left again. At 2:41 PM, R91 returned to R36 and R37's room and touched R36's bedding. R91 removed all the bedding from R36's bed and put it on the windowsill and left the room. R91 entered R10s again and took all the linen off R10's roommate's bed. R91 left R10's room at 2:45 PM. On 9/18/2025 at 8:45 AM, V6 (LPN) said R91 was constantly pacing, walked into other residents' room, and picked up their stuff. V6 said R91 did not sleep for long periods of time and agitated other residents. V6 said R91 required more supervision, as they did not always know what he was doing and did not have enough staff to constantly monitor him. V6 said he told the Director of Nursing (DON-V2) about his concern and had not heard back about an intervention for him. V6 said R50 fell because R91 was in her room. On 09/18/2025 at 9:11 AM, V9 (CNA/Certified Nurse Assistant) said R91 was hard to care for, and needed supervision because he required constant redirection. V9 said R91 wandered everywhere and got into everything. V9 said R91 had his favorite rooms that he constantly went in to, which were R10, R36, and R37's rooms. On 09/18/2025 at 9:15 AM, V8 (CNA) said R10 told her R91 kept coming into her room. V8 said it was a problem and that R91 needed more 1 on 1 attention. On 9/18/2025 at 9:20 AM, R10 said R91 had already entered her room twice that day and at 9:20 AM, R91 (who was last seen in R36's room) re-entered R10's room. R91 had R36's walker and brought it to R10's room. R10 said if she left her door open, R91 would come into her room. R10 said a few days earlier, R91 came to her room, took her blanket, and would not give it back to her, saying "it's mine." R10 said she was afraid to say anything to him because she was afraid that he would hit her. On 09/17/2025 at 2:08 PM, R36 said R91 was in her bed, and he was "all over the place." R37 was not interviewable. On 09/17/2025 at 10:50 AM, V12 (Family Member) said the staff told the family R91 wandered into other residents' rooms. V12 said the family was told he wandered into another residents' room and the other resident fell. V12 said she felt the facility was not watching him enough.	S9999		

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S9999	Continued from page 5 On 09/17/2025 at 2:26 PM, V10 (CNA) said he regularly took care of R91. V10 said R91 wandered everywhere and did whatever he wanted to do. V10 said R91 wandered into other residents' room and went through their stuff. V10 said they tried to redirect him. V10 said he worked on 9/14/2025 and R91 was in R50's room when she began screaming and fell. V10 said he did not think R91 should be walking around independently, as it could be a danger to other residents. V10 said pretty much all the residents said they were afraid of him coming into their rooms. V10 said there was not much he could do and had not reported this to anyone. On 09/18/2025 at 1:21 PM, V2 (DON) said she was aware R91 wandered, and he should be redirected. V2 said R91 should not be unsupervised in other residents' rooms. V2 said the staff should redirect R91 to the common areas to supervise him and keep him busy. V2 said she knew R91 wandered into R50's room, which startled her and caused her to fall. V2 said she was told R50 saw someone standing over the closet, got scared, and fell out of bed. The facility's Safety and Supervision of Residents policy reviewed 3/2025 showed Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Our resident-oriented approach to safety addresses safety and accident hazards for individual residents. Staff may use various sources to identify risk factors for residents, including the information obtained from medical history, physical exams, observation of the residents, and the MDS. The facility-oriented and resident-oriented approaches to safety are used together to implement systems approaches to safety, which consider the hazards identified in the environment and individual resident risk factors and then adjust interventions accordingly. Resident supervision is a core component of the system's approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. 2. On 9/18/25 at 11:50 AM, R19 was observed up in a positioning wheelchair with her sister visiting at bedside. V30 (CNA/Certified Nursing Assistant), entered R19's room to prepare her for transfer. After V30 exited the room, R19 was observed laying on her bed. During interview, V30 stated that he transferred R19 manually by himself since the full-body mechanical lift pad was not under her. V30 further stated he was not sure how R19 is supposed to be transferred and stated	S9999		

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S9999	Continued from page 6 he should have asked the nurse for clarification. Per V33 (LPN/Licensed Practical Nurse), she thought that V30 used the full-body mechanical lift for R19. V33 stated that R19 requires a two-person assist with the use of a full-body mechanical lift for all transfers. Review of R19's face sheet identified diagnoses including paraplegia, history of subarachnoid hemorrhage, Huntington's disease, epileptic seizures, and progressive neuropathy. Review of the MDS dated 9/2/25 showed that R19 is dependent on staff for transfers. Review of the facility's policy titled "Limited Lifting Resident Handling Policy," last reviewed November 2022, stated that "to protect the safety and well-being of staff and residents and to promote quality care, the facility will use mechanical lifting devices for the lifting and movement of residents." The policy further stated that mechanical lifting devices require the assistance of two staff members and that manual lifting is not permitted. 3. On 9/17/25 starting at 12:06 PM, lunch was observed in dining room. R75 was seen feeding himself and coughing on and off to the point where he was taking deep breaths to catch his breath. There were no staff in the dining room supervising meal time. R75 was heard and seen having three separate coughing fits during lunch service when no staff was present to supervise. On 9/18/25 at 3:30PM, V2 (DON/Director of Nursing) said residents eating in the dining rooms are supposed to be supervised by staff while eating related to choking concerns. V2 said if a resident is experiencing coughing fits while eating, there is a concern that the resident could be aspirating food into their lungs or choking. V2 said if a resident does aspirate, this can lead to pneumonia. R75's Face sheet shows the following diagnoses: oropharyngeal phase dysphagia, dysphagia following cerebral infarction, protein-calorie malnutrition, and dementia. R75's MDS (Minimum Data Set dated 7/18/25 shows he requires supervision or touching assistance while eating. R75's Care Plan last revised 5/30/25 states R75 benefits from a mechanically altered diet related to diagnosis of dysphagia and he has had a history of significant weight change. Interventions include monitor and report as needed any signs or symptoms of dysphagia: pocketing, choking, coughing, etc. 4.On 09/16/2025 at 12:05 PM, an oxygen cylinder containing 1400 PSI (pounds square inch) of oxygen was in R78's room without a holder or restraint. R3, R8,	S9999		

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S9999	Continued from page 7 R41 and R72 reside in rooms on either side of R78's room. On 09/18/2025 at 2:04 PM, V2 DON (Director of Nursing) stated oxygen tanks should be stored in a holder, so they don't fall over and explode. The next day on 09/17/2025 at 10:58 AM, the oxygen cylinder containing 1400 PSI was still in R78's room without a holder or restraint. On 09/17/2025 at 11:16 AM, V7 LPN (Licensed Practical Nurse) assigned to R78 stated the oxygen cylinder should be in a holder because if it falls, it could act as a torpedo. The facility policy Oxygen Administration and Storage date 1/2025 states oxygen cylinders must be stored in racks with chains, sturdy portable carts or approved stands in designated areas. They may not be left free standing. (A) 2 of 2 300.1610d) 300.1630a)1) 300.1630a)2) Section 300.1610 Medication Policies and Procedures d) All medications administered shall be recorded as set forth in Section 300.1810. Medications shall not be recorded as having been administered prior to their actual administration to the resident. Section 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. 1) Medications shall be administered as soon as possible after doses are prepared at the facility and shall be administered by the same person who prepared the doses for administration, except under single unit dose packaged distribution systems.	S9999		

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S9999	Continued from page 8 2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. This requirement was NOT met as evidenced by: Based on interview and record review, the facility failed to ensure residents took their medications prior to signing the EMR (Electronic Medical Record) showing the resident received the medication. This applies to 1 of 6 residents (R78) reviewed for medication administration. The findings include: On 9/17/2025 at 8:51 AM, V7 (LPN/Licensed Practical Nurse) took R78's pills to his room. V7 handed R78 a medication cup with five pills in it and another medication cup with a liquid medication. R78 took the liquid medication, the ibuprofen, and the doxycycline. V7 exited the room prior to R78 taking all his medications. At 9:04 AM, R78's medication cup was on his bed with three pills left in the cup, covered by tissue paper. R78 said he took one pill every 30 minutes to an hour because he got a stomachache if he took them all at the same time. V7 (LPN) said the Flomax, Losartan, and Torsemide were left in the cup. R78 said he would take the water pill at 9:30 AM and the next one at 10 AM. On 9/18/2025 at 10:22 AM, R78 said he had not taken any of his inhalers or the Flonase in over a month because the medications were contraindicated for him due to other illnesses he had. On 9/18/2025 at 10:35 AM, V7(LPN) said she was supposed to stay in the room and watch the residents take their medications before leaving as they could drop them and not be aware whether they took all their medications, they could throw them away, or save them for later. V7 said if they did not want to take the medication at that time, she would have to return the pills. V7 said for R78, she stood outside his room to make sure he took all his medications, as he did not like to be watched. V7 said she was "sure" R78 took all his medications. V7 said she had previously seen little cups of medications in R78's room from previous shifts, and when she asked him why they were there, R78 would reply he was going to "take it later." V7 said she was not sure if he was permitted to do that. R78's September 2025 MAR (Medication Administration Record) showed V7 signed off all of R78's medications	S9999		

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S9999	Continued from page 9 as being administered, and showed the nurses having signed off R78 receiving his Albuterol Sulfate inhaler, Symbicort Aerosol inhaler, the ProAir RespiClick inhaler. R78's face sheet showed he was admitted to the facility with chronic obstructive pulmonary disease, asthma, congestive heart failure, cerebral infarction, hemiplegia and hemiparesis, hypertension, bipolar disorder, depression, anxiety disorder, pain, and patient's other noncompliance with medication regimen for other reason. The facility's Administering Medications policy revised 1/2025 showed Medications may be self-administered by residents who have been assessed and determined to be safe and upon physician order. The individual administering the medication shall initial the resident's Medication Administration Record (MAR) on the appropriate line and date for that specific day before administering the medication. Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that particular drug and document a rationale. (B)	S9999		