IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

February 05, 2019

Michelle Benae Bush, Registered Agent
Oak Lawn Respiratory and Rehabiliation Center, LLC
240 Fencl Lane
Hillside, Illinois 60162

RE:	Complaint #:	IL00107334
	Survey Date:	December 07, 2018
	Docket #:	19-C0039
	Violation Type:	Level A

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Oak Lawn Respiratory & Rehab.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Oak Lawn Respiratory & Rehab/December 07, 2018//RegAgent/S.Geer

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. OAK LAWN RESPIRATORY AND REHABILIATION CENTER, LLC, D/B/A, OAK LAWN RESPIRATORY & REHAB, Respondent.	)))))))))	Docket No. NH 19-C0039

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint IL00107334 Investigation conducted by the Department on December 07, 2018, at Oak Lawn Respiratory & Rehab, 9525 South Mayfield, Oaklawn, Illinois 60453. On February 04, 2019, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Oak Lawn Respiratory & Rehab, 9525 South Mayfield, Oaklawn, Illinois 60453 on May 13, 2017. The Facility's current license number is 0051144. The term of the conditional license shall be from March 04, 2019 to September 03, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON MARCH 04, 2019.

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$25,000.00**, as follows:

Type A violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210d)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department;

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation.

Plans of Correction, Hearing and Waiver Requests can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulation

Dated this 05th day of February, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. OAK LAWN RESPIRATORY AND REHABILIATION CENTER, LLC D/B/A, OAK LAWN RESPIRATORY & REHAB Respondent.	)	Docket No. NH 19-C0039

PROOF OF SERVICE

The Conditional License will follow under a separate cover letter.

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Michelle Benae Bush
Licensee Info:	Oak Lawn Respiratory and Rehabiliation Center, LLC
Address:	240 Fencl Lane Hillside, Illinois 60162

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 05th day of February, 2019.

Sammye Geer
Administrative Assistant
Long Term Care- Quality Assurance
Office of Health Care Regulations

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006779	A. BUILDING: _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LAWN RESPIRATORY & REHAB	9525 SOUTH MAYFIELD OAK LAWN, IL 60453

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 1897453/ IL 107334 - Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 3001210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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These regulations were not met as evidenced by:
Based on observation, interview and record review the facility failed to monitor and supervise a cognitively impaired resident by leaving the automatic doors at the facility entrance unlocked and unattended, and failed to stop the resident from exiting the front doors unsupervised. This failure affected 2 of 3 residents (R3, R8) reviewed for accidents and incidents in a total sample of 11. This failure resulted in R3, a cognitively impaired resident, leaving out of the facility on foot and walking towards a 6 lane intersection sometime between 9:00pm and 10:45pm. R3 fell down a parking ramp near a garage adjacent to the facility and struck the right side of the face. R3 was found by a non-facility staff person, the paramedics were called and R3 was transported to the hospital for evaluation and treatment.

Findings Include:

The Face sheet documents R3 is a 59 year old admitted to the facility on 1/25/16 with the diagnosis of the following: chronic respiratory failure, anoxic brain damage, chronic pulmonary obstructive disease, psychosis, muscle weakness related to a cardiac arrest, and tracheostomy status. The current Care Plan dated 11/1/18 documents R3 is at risk for falls and has impaired decision making, poor logic, and poor ability to understand cause and effect. The Minimum Data Set (MDS) dated 11/1/18 documents that R3 has a Brief Interview for Mental Status (BIMS) Score of 7 indicating that the resident has severe cognitive impairment. The Physician Order Sheet documents that R3 may go out on pass with family dated 11/23/17 and may go out on overnight pass per Nurse Practitioner (NP) dated 11/7/18. The Community Survival Skill

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Assessment dated 6/28/2017 documents R3 requires supervision while out in the community and is not a candidate for independent pass privileges. The Elopement Risk Review dated 11/1/18 documents R3 is not an elopement risk at this time.

The Incident Report dated 11/9/18 documents that R3 was displaying exit seeking behaviors after being made aware by family that they would be taking the resident out on pass. The police report dated 11/9/18 documents R3 was dressed in cold weather attire to leave with a family member. R3 left the facility on foot before the family member arrived on scene. R3 walked to a medical office building adjacent to the facility on a 6 lane, high traffic intersection. R3 fell down a parking ramp near a garage adjacent to the facility and struck the right side of the face. R3 fell. R3 was found by a community person and transported to the emergency room before it was known that R3 was a resident of the facility. 911 was called at 11:13 PM, and the police notified the facility at 11:37 PM that the resident was found outside and was taken to a nearby hospital.

On 12/04/18 at 10:32am V2, Director of Nursing (DON) stated, "The only exiting seeking behavior the resident showed was refusing to remove the coat and hat. R3 had the coat on all day and was waiting to go home. R3 had an urgency of wanting to go home after being out on pass with family and would continue to ask to go home with family. All of the staff working that day saw the resident with the coat on. R3 was able to put the coat on without assistance and only needed help with the zipper. When the CNA (certified nurse aide) went to do night care that day the resident refused and kept saying I'm going home. R3 can walk with 1 person physical assist but is able to

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ambulate alone; I'm just not sure for how long. The only intervention in place was redirection. R3 never wandered or tried to exit the facility. The resident's room was located on the North wing of the first floor in the middle of the hallway. The resident had to pass the Nurse's Station when exiting through the front door. None of the staff saw the resident leave the building. The front doors are always locked by the receptionist at 8pm when the receptionist leaves for the day. The only camera we have is the one outside above the door but we did not review the camera footage. All staff enters and exits through the front door."

The hospital record dated 11/10/18 documents R3 presented to the emergency room after being found wandering outside. R3 reportedly escaped from the nursing home for no more than a 12 hour period. A bystander called emergency medical services after witnessing R3 fall and strike the right side of R3's face. R3 complained of facial pain on arrival. R3 was given a baseline neurological exam and there were no deficits noted. Computed tomography (CT) scan of the head was negative for fractures or brain bleeds but showed some bruising of the right facial bone under the eye.

On 11/16/18 at 12:23 PM, V2 stated, "The family has to check the resident out with the nurse before leaving the building. The sign out book is left at the receptionist desk, even after hours, and family should see the nurse and then sign a resident in and out before leaving the facility. That didn't happen here."

On 11/16/18 at 2:12 PM, V2 stated "Some of the residents watch staff leave the building and they know how to use the switch above the door to get

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in and out of the building. Also staff enters and exits through the front door and should have another staff member lock the door behind them at night."

On 11/16/18 at 1:49 PM, V4 (LPN) stated, "I was on break at 9:30 PM - 10:00 PM and saw a car waiting in the front. I assumed it was R3's family coming to pick the resident up. I didn't see R3 in the car, and I didn't see R3 leave the building."

On 11/16/18 at 1:59 PM, V5 (Manager on duty) stated, "When I left that night, I saw the family's truck outside the facility. I assumed they were picking up R3."

On 11/16/18 at 2:30 PM, V6 (LPN) stated, "I work the night shift (11 PM - 7 AM) so when I came in, the evening nurse told me R3 was supposed to go out on pass with family but R3 was missing. The evening nurse checked the bathroom but R3 was not there. R3's family member was here too. They started looking around upstairs in other rooms. I went downstairs to clock-in and I did not see R3 in the basement. We then went to look in the back of the facility to see if the resident got out that way, but R3 wasn't there. That's when the Police came and asked if we were missing anyone and we told them 'Yes'. The Police said R3 had been taken to the emergency room. The family member told us R3 had never left the facility with family."

On 11/16/18 at 3:00 PM, V2 stated, "On the night of November 9th, there were three call offs so the manager on duty and myself stayed until about 9:00 PM that night to help out. R3 was still here waiting on family when I left."

On 11/16/18 at 3:36 PM, V7 (CNA) stated, "R3's

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family member came around 10:00 PM and went into R3's room. The family member came out and said, 'Where's R3?' I told the family member that R3 had left with a different family member that was visiting the resident that day. The family member told me, 'There's no way because the other family member is at home right now. I have been trying to get a ride all day for R3 so I just came now.' I told the nurse, and we all started looking for R3."

On 11/20/18 at 2:47 PM, V13 (Nurse Practitioner) stated, "R3 can't take care of self so R3 should not be out in the community alone. R3's cognition is impaired. I would say R3 is alert and oriented to 1-2 (self and place) depending on the day."

On 11/20/18 at 3:03 PM V2 stated, "No staff told me they saw R3 with a family member. We just all assumed the resident left with family because of the family's car being in the parking lot and staff seeing the family member carry out R3's clothing and incontinence briefs."

On 11/21/18 at 11:00 AM, V9 (LPN caring for R3) stated, "I never saw R3 leave the building with a family member. I just thought that's where R3 went because R3's family member was here all day with R3. I didn't hear any alarms go off that night."

On 11/16/18 at 9:00 AM upon entering the facility it was noted that there were 2 sets of automatic double doors that enters into the lobby and leads to the first floor nursing unit. When exiting the lobby and leaving the facility both sets of doors has an ON/OFF switch that measures approximately 67 inches from the floor. There are no alarms or keypads attached to the automatic doors leaving the facility. Once the double doors

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are switched into "ON Mode", they will automatically open.

On 11/20/18 at 9:55 AM, V1 stated, "We put in an alarm on the front door over the weekend. If someone tries to leave the building after the door is locked, an alarm will sound. The building has never had this before. Now all visitors will sign out with the Nurse."

On 11/20/18 at 11:08 AM, V2 stated, "The front door is locked at 8:00 PM by the receptionist. After that the first floor staff is responsible for locking the doors after they open them to let someone in or out. There is a sign in and out book at the receptionist desk. After hours, the nurse should be seen to sign residents out before a resident leaves the facility. The nurse is always seen to make sure the resident has all needed medications."

On 11/20/18 at 1:40pm an environmental tour was done to check all doors exiting the facility. There are 4 doors located on the first floor that can be used to exit the building. The door on the south end of the building and the back of the building has a key pad and requires a code to be entered before the door can be opened. The door on the North end of the building and a door in the dining room leading to the patio can be opened but an alarm will sound until a code is entered into the key pad. The resident is believed to have left through the 2 sets of automatic double doors in the front of the building because no alarms were heard during the time the resident left the facility.

On 11/28/18 at 9:48 AM, V1 demonstrated the front door alarm system to the surveyor. After hours, a code is entered into the key pad, then a

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S9999	Continued From page 7 switch above the door is turned to "night mode" which allows the door to remain locked preventing anyone from entering or exiting the building. Once the door is taken off of "night mode" the door will open, but an alarm sounds above the door when someone attempts to exit the building. V1 stated, "Only this alarm sounds. No other notifications are sent anywhere else in the facility. We never looked at the camera footage, everything erases in 72 hours. By the time the surveyors entered the facility, the footage would have been deleted." (A)	S9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: OAK LAWN RESPIRATORY & REHAB COMPLAINT #: 0107334
LIC. ID #: 0051144
DATE COMPLAINT RECEIVED: 11/15/18 14:33:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
401	INVOLUNTARY TRANSFER	2

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.