STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Lawn Respiratory & Rehab	9525 South Mayfield Oak Lawn, IL 60453

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their elopement policy by not allowing a resident to leave the facility unauthorized without staff knowledge. This affected one of three residents R1 reviewed for leaving the facility unauthorized. This failure resulted in R1 being found about 450 ft from the facility walking down the street within minutes after leaving. Findings Include: R1's hospital referral package dated 6/16/25 documents: Per emergency department patient (R1) with tendency to roam the street. Psychiatric: Cognition and Memory: Cognition is impaired. Memory is impaired. Comment: Highly impaired insight plus judgement. R1 was admitted on [DATE] with the diagnosis of Dementia with other behavioral disturbance. Minimal data set dated [DATE] documents a score of twelve which indicates moderate cognitive impairment. Nursing note dated 6/20/25 documents: Resident (R1) is alert, forgetful and oriented to self and situation. Elopement Risk Review dated 6/20/25 documents: Ambulation: Confined to chair/bed (non-mobile without assistance) no; Predisposing diseases/condition: Does resident have a diagnosis of Dementia/ Alzheimer's or severe mental illness or period of confusion: yes; Cognitive process: does resident pace or wander: yes; History of elopement episodes for the past three (3) months: yes; Does the resident readily accept nursing home placement: no Elopement risk: score twenty-one(21); Category: High Risk for Elopement. R1's care plan initiated 6/20/25 documents: Resident (R1) demonstrates movement behavior that may be interpreted as wandering, pacing or roaming related to the diagnosis of Dementia and problems understanding the immediate environment. Attempting to leave facility without a responsible escort (elopement). Pacing, roaming or wandering in and out of peers' rooms. Engaging in theme behavior, believes he/she is in another time and place with specific responsibilities (must deliver mail due to being a retired mail carrier), the resident is a new admission and not familiar with his/her environment. Nursing note dated 6/21/25 documents: 72 hour charting: Resident (R1) up and about. R1 is alert and orient 1- 2 with confusion, at baseline. R1 indicated to exhibit wandering behavior and is being monitored closely by staff for safety. Community Survival Skills assessment dated [DATE] documents: Due to R1 diagnosis of Dementia, R1 does not appear to be capable of unsupervised outside pass privileges at this time.Nursing note dated 7/4/25 created 7/14/25 documents: (V8 nurse) Writer was informed by staff that the (R1) attempted to exit the facility with accompanying (R2) peer's family members. All families entering the building have been educated not to allow residents to join them in the elevator, given that this is a secure unit with elopement precautions in place. R1 was observed on the first floor; the (V9) receptionist promptly notified nursing, and R1 was redirected back to her room. R1 was reoriented to baseline, with education provided that R1 resides in the facility and may leave only with approved pass authorization from her POA. R1 is known to wander and is considered an elopement risk.Physician Progress note dated 7/4/25 created 7/16/25 documents: V11 (nurse practitioner) Writer informed by V2 DON via message that patient (R1) was noted on the first floor after being on the elevator with another patient family that was leaving the unit. R1 was redirected and assisted back to the second floor. Spoke with nurse on duty and discussed elopement precautions and frequent rounding to be done to ensure R1 does not exit unit unless supervised by POA or staff due to being elopement risk with diagnosis of dementia, understanding voiced. Per nurse on duty the R1 did not leave the building and was easily redirected back to the unit. V11 request that families are made aware that staff should be notified of any residents attempting to leave the unit via elevator when they exit the facility. On 7/16/25 at 9:26am, V3 (complainant) said, she and V4 saw R1 on 95th street (7/4/25 @ 3pm) getting ready to cross the street. On 7/16/25 at 10:00pm, V4 (cna) said, he was off work. V4 said, he left the building around 3:15pm. V4 said, he saw R1 walking down 95th street. V4 said, he called out to R1, asked R1 what she was doing to which R1 replied taking a stroll. V4 said, he brought R1 back to the building, stop at V9's desk to inform her that R1 was found outside the building on 95th street. V4 said, he took R1 to V8 (nurse). V8 was the nurse on R1's unit. V8 did not know R1 left the building. V4's witness statement dated 7/17/25 documents: On July 4th, V4 saw R1 on 95th and walked R1 down the street back into the building. Let the front desk know and then took R1 back upstairs. On 7/16/25 at 10:58am, V8 (nurse) said, R1 attempted to exit the facility with R2's family. R1 went down the elevator. V4 (cna) brought R1 back to the unit. V8's statement documents: On 7/4/25 at 2:40pm, V8 was making the schedule for 3-11 shift when V9 called and asked if R1 was on the unit. V8 completed a head count with peer nurse. R1 was coming off the elevator with cna. On 7/16/25 at 11:02am, V5 (cna) said, she was sitting in the hallway at the end of R1's unit, because R1 got onto elevator, that