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	01/30/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its Guidelines for Incontinence Care by not providing timely incontinence care to dependent residents. This applies to 3 of 3 residents (R3, R6, and R11) reviewed for activities of daily living in a sample of 11.The findings include:1.R3 is a [AGE] year-old female admitted with mild cognitive impairment as per MDS dated [DATE]. The MDS also documents that R3 is dependent on toileting hygiene.On 1/27/26 at 10:05 AM, R3 was observed in her bed and stated, They changed me last night, and I think I am wet.On 1/27/26 at 10:22 AM, R3 was observed with dark blackish colored incontinent brief with a strong odor of urine and feces.On 1/27/26 at 10:22 AM, V19 (Certified Nursing Assistant / CNA) stated, I got here at 7:00 AM. I was passing trays and didn't get a chance to change her. I am on my way to change her.On January 28, 2006, at 10:42 AM, R3 stated that she had not changed yet. On 1/28/26 at 10:43 AM, V20 (CNA) stated, I was just pulled from the second floor to the first floor now, and I didn't change R3 yet.On 1/28/25 at 10:50 AM, observed V20 and V21 (CNA) providing incontinent care to R3. R3 was observed with a moderate wet brief with urine.A review of the restorative care plan document that R3 was care planned for neuromuscular bladder dysfunction/incontinence with intervention including check the resident (every 2 hours) and as required for incontinence. Wash, rinse, and dry the perineum. Change clothing PRN after incontinence episodes.2.R6 is a [AGE] year-old female admitted on [DATE], having severe cognitive impairment as per the MDS dated [DATE]. The MDS also documents that R6 is dependent on toileting hygiene.On 1/27/26 at 1:00 PM, R6 was observed in her bed with her fiance (V18) at her bedside. V18 stated, I was here at 8:40 AM, and nobody checked on R6 between 8:40 AM and 12:40 PM. R6's incontinent brief was heavily soaked with bowel movement and was smelly, and they changed her at 12:40 PM.A review of the care plan document that R6 was care planned for incontinence with interventions including administering appropriate cleansing & peri-care after each incontinent episode.3.R11 is a [AGE] year-old female admitted on [DATE], having cognition intact as per the MDS dated [DATE]. The MDS also documents that R11 is dependent on toileting hygiene.On 1/28/26 at 10:35 AM, R11 stated, I am waiting to be changed. I was changed in the early morning by the night staff. R11 initiated call light, and V20 checked on R11, and R11 was observed with a moderately wet, brownish colored incontinent brief.On 1/28/26 at 10:40 AM, V20 stated, They just moved me from the second floor, and I didn't get a chance to change R11. I didn't get any report as no nursing assistant was assigned to R11. I am going to change R11 now.A review of the care plan document that R11 was care planned for overactive bladder with interventions including assist with toileting needs.On 1/27/26 at 10:35 AM, V2 (Director of Nursing / DON) stated that their staff is supposed to change incontinent residents every two hours and as needed.A review of the facility provided an undated Guidelines for Incontinence Care document: It's the policy of the facility to ensure that residents receive as much assistance as needed for cleaning the perineum and buttocks after an incontinent episode or with routine daily care. Frequency (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depends on the bladder's daily result and/or routine minimal every two-hour check, as well as care planning.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the physician's order to provide wound treatment and care. This applies to 1 of 3 residents (R3) reviewed for wound treatment and care in a sample of 11.The findings include:R3 is a [AGE] year-old female admitted with mild cognitive impairment as per MDS dated [DATE]. R3 was admitted with an admitting diagnosis including paraplegia, pancreatic cancer, multiple stage-4 sacral pressure ulcers, and diabetes.A review of the wound assessment dated [DATE] by V23 (wound care physician) documented multiple chronic wounds, including a stage 4 left hip, stage 4 sacral, stage 4 left ischium, stage 4 right buttocks, and a stage 3 right heel.On 1/28/25 at 10:50 AM, observed V20 and V21 (CNAs) providing incontinent care to R3. During incontinence care, R3 was observed with a stage 4 sacral and stage 4 left ischium wound with soiled and dirty dressings peeling off and dated 1/26/26.On 1/28/26 at 11:25 AM, observed V22 (Licensed Practical Nurse / LPN) providing wound care to R3's multiple sacral wounds. During wound care, V22 stated that the old dressing is soiled, dirty, and peeling off with date 1/26/26 indicates that nobody provides wound care yesterday.On 1/28/26 at 11:30 AM, observed V22 cleanse the wound with saline, pat dry, medi honey, and calcium alginate applied to stage 4 sacral and stage 4 left ischium wounds.A review of the Physician Order Sheet (POS) and Treatment Administration Record (TAR) document sacral and left ischium wound care document to apply (product) after cleansing site and then covering with Silicone super absorbent dressing daily and as needed.On 1/28/26 at 11:30 AM, V22 stated that she is aware of the (product), and she couldn't find it in the treatment cart to apply to R3's sacral and left ischium dressing change.On 1/29/26 at 9:20 AM, V23 (Wound Care Physician) stated, R3 was admitted with those chronic wounds. I ordered (the product), which will debride the dead tissue from the wound bed. The facility should have used the (the product as ordered) to change the wound dressing.The facility presented an undated Wound Cleansing and Dressing Policy document: It is the policy of the facility to perform wound dressing changes as ordered by the physician using a clean technique on all chronic or contaminated wounds.