2017 IL App (1st) 160839-U

FIRST DIVISION
June 12, 2017

No. 1-16-0839

NOTICE: This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1).

IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

CONCEPTS PLUS, INC., d/b/a PINE TERRACE,	)	
	)	Appeal from the
Plaintiff-Appellant,	)	Circuit Court of
	)	Cook County.
v.	)	
	)	No. 14 CH 2367
THE DEPARTMENT OF PUBLIC HEALTH;	)	
NIRAV D. SHAH, Director of Public Health; LAMAR	)	
HASBROUCK, Director of Public Health; and DAVID	)	Honorable
N. CARVALHO, Deputy Director of Public Health,	)	Neil H. Cohen,
	)	Judge Presiding.
Defendants-Appellees.	)	

JUSTICE MIKVA delivered the judgment of the court.
Presiding Justice Connors and Justice concurred.

ORDER

¶ 1 *Held*: We confirm the decision of the Illinois Department of Public Health with the reduction in fine imposed by the circuit court where the decision of the administrative agency was not clearly erroneous, an abuse of discretion, or against the manifest weight of the evidence.

¶ 2 After an administrative hearing, the Illinois Department of Public Health (the Department) issued an order finding that plaintiff, Concepts Plus, Inc., d/b/a Pine Terrace (Pine Terrace), violated five sections of the Intermediate Care Developmental Disability Facilities

Code (Code) (77 Ill. Adm. Code 350.110 *et seq.*), assessing a fine of $20,000, and affirming the issuance of the facility's conditional license. The circuit court, on appeal, reversed the Department's finding as to one violation, affirmed its findings as to the remaining violations, and remanded the matter to the Department to make a corresponding adjustment to the amount of the fine imposed on Pine Terrace. On remand, the Department's amended order reflected this partial reversal, but failed to change the amount of the fine. The circuit court reduced the fine to $16,000 on a second appeal and again remanded the case to the Department for imposition of the reduced fine. On appeal, Pine Terrace challenges the circuit court's orders only with respect to the four remaining violations, asking this court to vacate all fines and sanctions imposed by the Department in connection with those violations. For the following reasons, we confirm the order issued by the Department, as modified by the circuit court.

¶ 3 BACKGROUND

¶ 4 Pine Terrace is an intermediate care facility for adults with developmental disabilities. On May 6, 2010, the Department inspected Pine Terrace pursuant to section 350.200 of the Code (77 Ill. Adm. Code 350.200 (1995)) in regards to unrelated incidents involving two Pine Terrace residents, who have been referred to throughout these proceedings as R2 and R4, respectively. Following these inspections, the Department issued Pine Terrace a notice citing the facility with a total of seven "Type A" violations of the Code (see 77 Ill. Adm. Code 350.330 (2006)), assessed Pine Terrace a fine of $40,000, ordered it to immediately remedy these violations, and issued it a temporary "Conditional License" for the operation of the facility that was conditioned upon its compliance with the notice. Pine Terrace contested the notice at an administrative hearing.

¶ 5 A. Administrative Hearing

¶ 6 The three-day administrative hearing took place in September 2013. The evidence put forth at the hearing included the testimony, summarized below, of the two Department surveyors who investigated the incidents and six individuals who worked at Pine Terrace or other related facilities and who provided a first-hand account of the incidents in question.

¶ 7 1. R4

¶ 8 R4 was a 50-year-old male resident of Pine Terrace who was nonverbal and diagnosed with profound mental retardation and seizure disorder. R4 was taken to the hospital on March 18, 2010, and was diagnosed with pneumonia. He was released the same day with a prescription for antibiotics and instructions for his care. R4's condition severely worsened and he was admitted to the hospital on March 28. Several days later, R4 was put on life support, and he died on April 4 when his guardian elected to discontinue treatment. The Code violations Pine Terrace was cited for in connection with R4 included the failure to notify R4's physician of a change in his condition that threatened his health, and the failure to provide adequate professional nursing services to meet R4's needs.

¶ 9 a. Stephen Troop's Investigation

¶ 10 Stephen Troop, the health facility supervisor who investigated this incident for the Department, testified that his investigation involved reviewing R4's records and interviewing about a dozen employees of both Pine Terrace and Lakeside Day Training Center (Lakeside), where R4 attended vocational training on weekdays. According to Mr. Troop's investigation, R4 first demonstrated symptoms of pneumonia on March 18 when he was at Lakeside. The Lakeside staff called the paramedics, and R4 was taken to the emergency department at Vista Medical Center (Vista), where he was treated, placed on the antibiotic Levaquin with orders to continue

taking it for 10 days, and discharged with care instructions. R4 began taking the antibiotic on March 19 and completed the 10-day regimen as prescribed.

¶ 11 Mr. Troop testified that the discharge instructions were not specific to R4, but were written for patients with pneumonia. The instructions required a physician to be notified if the patient had a fever of over 101 degrees Fahrenheit that was not relieved by medicine, if he continued to have a fever after two to four days of treatment, if he coughed up smelly or blood-tinged sputum, if he developed shortness of breath or chest pain, if he did not improve within three to five days, or if he otherwise seemed to be getting worse and not better.

¶ 12 The nurse consultant for Pine Terrace, Chris Helfrich, created progress notes to track R4's condition. Nurse Helfrich had no direct contact with R4 between March 18 and 28; her notes were created "[f]rom phone conversations, with staff, through e-mails." Nurse Helfrich told Mr. Troop that "once she tells a staff person [instructions] over the phone, it's that staff person's responsibility to instruct the other direct care staff on what's to be monitored for R4." Based on what Nurse Helfrich told Mr. Troop, it was his understanding that Pine Terrace staff was "monitoring and observing" R4 and would report to Nurse Helfrich.

¶ 13 Mr. Troop testified that R4's March 19 progress note indicated that he had no shortness of breath, that he had "minimal nonproductive cough intermittently," and that he was afebrile, *i.e.*, had no fever. On March 20 and 21, there was no documented record of R4 demonstrating a fever or other symptoms listed on the discharge instructions that would require a physician to be notified.

¶ 14 Lakeside required doctor's approval before R4 could return to that facility. On March 22, Pine Terrace took R4 to the physician's office and he was examined by a physician's assistant. According to the physician's assistant's notes and the physician's order issued during that visit,

the care plan was to continue present management; R4 would continue taking the antibiotics and take Robitussin as needed. R4 stayed at Pine Terrace on March 22 and 23, and returned to Lakeside on March 24.

¶ 15 Mr. Troop testified that, according to Lakeside staff, from March 24 to March 26, R4 appeared "[l]ethargic, very tired, very quiet, [and he] refused to engage." At Lakeside on March 26, R4 had a fever of 99.5 degrees and "was very lethargic, very tired, coughing," and he kept his head down on his desk. Because no one from Pine Terrace was available to bring R4 home; the decision was made to keep him at Lakeside and reevaluate his condition after lunch. "Purportedly there were no other symptoms at that time after lunch" and R4 remained at Lakeside until the end of the day. Mr. Troop testified that on March 26 there is a record of R4 moaning, but he saw no documentation of R4 wheezing, having shortness of breath, or having trouble breathing.

¶ 16 On March 28, R4 ate breakfast but later did not want to come out of his room for lunch. He was given milk and juice and "went right to bed." Medication administration records indicate that R4 was given Tylenol at 9:10 a.m. and medication for a "[p]ainful cough" at 1 p.m. R4 stayed "under covers" after that and his dinner was brought to him at 5:20 p.m. By the time he was checked at 8 p.m., R4 "was in a state of distress"—staff believed he had a fever but were unable to take his temperature—and he was "moaning" as he was transported to the hospital. The physician's assistant told Mr. Troop that neither she nor the doctor was made aware of R4's fever on March 26 or 28; nor were they contacted about R4's condition at all after March 24.

¶ 17 On March 30, R4 was placed on a ventilator. He passed away on April 4 when his guardian elected to discontinue life support.

¶ 18 b. Lakeside Day Training Center Staff

¶ 19 Three Lakeside employees also testified at the hearing that, on March 18, 2010, R4 "was not himself" and appeared to be ill: he was coughing and "shaking uncontrollably," his jaw was clenched, and he felt warm to the touch. R4's temperature was 100 degrees Fahrenheit. After Pine Terrace was notified of his condition, Lakeside called paramedics, who arrived and took R4 to Vista.

¶ 20 Lakeside's note for R4 for March 24 stated that he "appeared lethargic, head down, refused to communicate, appeared tired today. Refused to engage. Very quiet today." His March 25 note repeated essentially the same things and his March 26 note stated that he "appeared tired today. He had a cough today and fever. [Pine Terrace] staff was notified, reported."

¶ 21 c. Kira Grahame

¶ 22 Kira Grahame testified that in March 2010 she was a regional trainer for Lakeside assigned to a region that included Pine Terrace. According to Ms. Grahame, Pine Terrace staff would have documented R4's temperature if it was "over whatever was indicated by the physician." Although R4 could not communicate changes in his condition verbally, he was able to use non-verbal communication to show if he did not feel well, and Pine Terrace staff was trained to recognize "visual symptoms" of individuals to determine when someone's condition had changed.

¶ 23 Ms. Grahame testified that after R4 visited the physician's office on March 22, the physician's note allowing him to return to Lakeside noted that he "didn't show any further signs or symptoms" of pneumonia, but was "showing some cough intermittently." The note instructed the staff to "keep an eye on his condition," to "continue present management," and that R4 "was to return to work after a couple days of rest."

¶ 24 Ms. Grahame reviewed the notes regarding R4 after she returned from vacation on March 30. She testified that there were two March 24 progress notes created regarding R4. These notes indicated that R4's temperature was 101.3 degrees Fahrenheit at 7 p.m. and 100.9 degrees at 7:30 p.m. Staff administered Tylenol at 7:45 p.m. and R4's fever subsided; his temperature was 100.3 degrees at 8:15 p.m. and 99.8 degrees at 8:30 p.m. Staff was instructed to call the trainer if his temperature exceeded 100 degrees and she would then take him to the emergency room; when she called at 10:45 p.m. to check on him, R4's temperature was "staying below 100 [degrees]."

¶ 25 Ms. Grahame testified that she never became aware of R4 having a fever over 101 degrees that was not relieved by medicine. She also never uncovered any information to establish that R4 "had a cough that produced smelly or blood-tinged sputum," that he ever "developed shortness of breath," or that between March 18 and 27 his condition appeared to be getting worse. She testified that, based on her review, he appeared to be getting worse on March 28, the day he was taken to the hospital.

¶ 26 d. Nurse Chris Helfrich

¶ 27 Nurse Helfrich testified that, as a registered nurse in March 2010, she was involved with about six facilities at once, including Pine Terrace. She stated that she was at Pine Terrace about once per week, and the amount of time she spent there for each visit varied. She would come to Pine Terrace for "[r]outine visits" and she generally saw residents and did assessments on a monthly basis. Nurse Helfrich testified that she also came "as needed," such as when staff asked her to see a resident for a personal assessment. Nurse Helfrich testified that she was not certain whether she ever came to Pine Terrace between March 18 and 28, or at all during that month. Although she stated that she met with R4 on a regular basis—on average "at least twice a month,"—according to her notes, the last time she saw R4 in person was on February 11, 2010.

¶ 28 Nurse Helfrich learned on March 18, 2010, that R4 had pneumonia from a report she received following his treatment in the emergency room; her progress indicated that she received "a verbal report from the staff." The next day, on March 19, Nurse Helfrich created another progress note after receiving R4's discharge instructions from the hospital, along with updates about R4 that she received from staff. She stated that the discharge instructions were "educational forms" that were "just generic standard, informational." At that time, it was her understanding that R4 was "doing well" and was not running a fever, was taking his medication, did not have any shortness of breath, and had "a slight cough." Based on that, she testified, there was no reason to implement different orders or change what staff was doing.

¶ 29 On March 19, Nurse Helfrich created a medication instruction form instructing Pine Terrace staff to give R4 Levaquin for 10 days to treat his pneumonia, to encourage R4 to drink at least six to eight glasses of water daily, and to monitor his condition. She also told them inform her if R4 had a temperature of over 100 degrees.

¶ 30 Nurse Helfrich created another progress note on March 22, based on the update Pine Terrace was given following R4's visit to the physician's office. Her note stated:

> "R4 to physician for follow-up of treatment of pneumonia. Cough continues. Robitussin DM [as needed] order received. Staff in-serviced unchanged [*sic*]. R4 remains afebrile, infection control maintained within the facility. R4 to return to the physician as indicated."

¶ 31 Although Pine Terrace documentation indicated that R4 had a fever on March 24, Nurse Helfrich did not specifically recall whether she was notified of this. Based on his temperature and her March 19 instructions, however, she would have expected to be notified. Nurse Helfrich testified that she created a progress note for R4 on March 28, based on a report from staff,

indicating that R4 was "oppositional to his activities of daily living assistance, and that he appeared sleepy" prior to being taken to the hospital.

¶ 32 She was not notified of R4's fever or his "painful cough" on March 28, but, based on her March 19 instructions, "[a]s well as just general expectation," she would have expected to hear about these "changes." In her opinion, R4's condition did not require her physical presence to provide appropriate nursing services to him. Nurse Helfrich testified that, based on her involvement with R4, she was not aware of him failing to improve prior to March 28, but on March 28 he met the criteria for a change in condition and failure to improve.

¶ 33 2. R2

¶ 34 R2 was a 67-year-old resident of Pine Terrace who was diagnosed with antisocial personality, seizure, and bipolar disorders. His IQ was 61 and functioned at approximately the level of a five-year-old child. R2 made the accusation that, on April 25, 2010, a Pine Terrace staff member hit him in the head with a showerhead while helping him take a shower. The Code violations Pine Terrace was cited for in connection with R2 included the abuse or neglect of a resident by a facility staff member and the failure of a staff member to immediately report the abuse or neglect of a resident.

¶ 35 a. Maila Caballes

¶ 36 Maila Caballes, the licensed registered nurse who investigated this incident for the Department, testified that, during the course of her investigation, she spoke with staff members at Northpointe Day Training (Northpointe), the facility where R2 went during the day to receive educational training; Kira Grahame; and R2 himself.

¶ 37 Ms. Caballes learned that on April 26, 2010, R2 told a Northpointe staff member about an incident that had occurred at Pine Terrace that upset him. Northpointe staff's incident report

documented R2's allegation that, "the night before *** he refused to take a shower, and the staff got upset and the staff pulled his shoulder and hit him in the head."

¶ 38 R2 told Ms. Caballes that a male staff member hit him with the showerhead because he did not want to take a shower, and one other staff member witnessed the incident. R2 claimed that when he later talked to that other staff member, she denied seeing it.

¶ 39 Ms. Caballes testified that she spoke about the incident on multiple occasions with Ms. Grahame. The first time they spoke, Ms. Grahame had just become aware of the incident and said that she would conduct an investigation. Ms. Grahame later told Ms. Caballes that Dawn Johnson, the other staff member present, did not immediately report the incident, but told Ms. Grahame about R2's allegation when Ms. Grahame sought her out for an interview. Ms. Grahame stated that R2 later recanted his allegation.

¶ 40 Ms. Caballes determined that Eric Goodenough was the staff member who showered R2 and who R2 alleged pulled his arm and hit him with a showerhead. Although Ms. Caballes testified that Mr. Goodenough and Ms. Johnson were the individuals who assisted R2 with his shower, she did not interview either of them during her investigation, nor did she examine R2.

¶ 41 b. Kira Grahame

¶ 42 Ms. Grahame began her investigation into the incident involving R2 on April 30, 2010. She first interviewed R2, who told her that "[t]he big guy pulled my shirt, grabbed me and pulled my arm into the shower. [Mr. Goodenough] makes faces at me and everybody. It was Friday night when [another Pine Terrace staff member] Edwina was off. I only shower when Edwina is here. I like [Ms. Johnson]. I refuse showers with him." R2 told Ms. Grahame that Mr. Goodenough was previously never mean to him and had never hit him before. R2 also told Ms. Grahame that one or two days earlier, he told Edwina about what happened.

¶ 43 Ms. Grahame then interviewed Pine Terrace staff members about the event. Mr. Goodenough and Ms. Johnson both told her that they showered R2 and that Mr. Goodenough did not hurt R2 in any way. Edwina told Ms. Grahame that she was not aware of any abuse in the facility or any incident involving R2. Ms. Grahame interviewed all of the other residents, and none indicated that there was any abuse—between Mr. Goodenough and R2, or any other staff or residents. Ms. Grahame confirmed that Ms. Johnson did not report R2's allegation to anyone.

¶ 44 When Ms. Grahame re-interviewed R2 after speaking to the staff members, she explained to him that no one was aware of any incident, and she asked whether it actually happened to him. R2 told her that Mr. Goodenough was helping him take off his shirt and was pulling on the sleeve, and R2 then told him that he wanted to do it himself. After that, Ms. Johnson came into the bathroom to help, and Mr. Goodenough did not hit him with anything. Mr. Grahame concluded R2's initial complaint was based on an unfounded allegation and no abuse between staff and residents had occurred. Ms. Grahame stated that, in her experience, this was not a "close call" investigation and that there was not any evidence that made her suspicious that R2 had been abused.

¶ 45 At the time of the incident, R2 had been living at Pine Terrace for almost 13 years. A behavior assessment recorded in his individual service plan dated May 2010 stated:

> "R-2 has a history of arguing; making threatening statements; complaining; yelling; non-compliance, including refusal to shower, refusal to go to work, refusal to participate in activities; and making false accusations.
>
> [R2] also makes threatening statements to staff, such as, I'm going to get you fired.

> They often occur when [R2] is asked to complete a task that he does not want to do, such as take a shower or participate in an outing."

Ms. Grahame testified that she believed this portion of R2's individual service plan, written in 2009, was consistent with his behavior prior to April 2010.

¶ 46 c. Dawn Johnson

¶ 47 Ms. Johnson testified that, on April 25, 2010, she and Mr. Goodenough helped R2 take a shower. Ms. Johnson stated that R2 "didn't want to take a shower" and was "crabby." Mr. Goodenough began to undress R2 without Ms. Johnson present; she did not recall how long the two were alone before she entered the room. Ms. Johnson was called in later, when R2 was partially clothed and sitting on the toilet. She then helped R2 stand up while Mr. Goodenough helped him finish getting undressed. At that time, R2 "was just like swearing at us, telling us why does he have to take a shower, you know. He was just aggravated, because he didn't want to take a shower. On a normal basis he didn't like to take showers." She explained that Mr. Goodenough washed R2 in the shower while she made sure that R2 did not fall. The showerhead was "one with a hose" that "comes off, comes down." According to Ms. Johnson, after Mr. Goodenough washed R2, he detached the showerhead from its holder to use it to rinse R2 off.

¶ 48 Ms. Johnson further described the scene:

> "After the shower when we were just finishing rinsing [R2] off and starting to dry him off, he was laughing and joking around with us. *** [Mr. Goodenough and I] were complimenting him, *** how well he looked and how handsome of a man he was. And [R2], he was laughing and joking with us and, you know, he wasn't angry, he wasn't in a bad mood anymore. He was, I think, happy that the shower was over with and that he did look better, and he did smell better."

They had R2 sit on the toilet, then Mr. Goodenough left and Ms. Johnson proceeded to dry R2 off and dress him. This is when R2 told her that Mr. Goodenough hit him in the head with the showerhead. Ms. Johnson testified that she did not see Mr. Goodenough hit R2 in the shower or be rough with R2 at all. Prior to drying him off, R2 did not say that he was hurt in any way. When R2 later made his accusation, she said to him: "Are you sure?" and R2 responded by looking down and not saying anything. According to Ms. Johnson, R2 never repeated his allegation any time after that.

¶ 49 Ms. Johnson explained that she was trained to identify the physical and behavioral signs of abuse. She stated that if there is an unexplained bruise or mark on a resident, or if she suspected another staff member abused a resident, she must document and report it. Ms. Johnson testified that R2's statements to her in the shower "didn't really have an effect on [her]" and she "didn't think he was really serious about it." She believed this because:

> "[W]hen I questioned him, his body language was as if he [wasn't] tell[ing] the truth. He looked down.
>
> He always made false accusations about other residents and other staff. He was happy and joking, I thought the situation resolved by the end of the shower. There was no reason for me to think that he had been hurt, and the showerhead couldn't even reach to the toilet where he was sitting, and so I just thought *** he was trying to get attention, like he did many times ***. He never brought it up again the rest of the day."

¶ 50 Ms. Johnson estimated the showerhead cord was "two to three feet" long, and the toilet was "across from the shower" on a different wall, with space between the toilet and the shower.

Ms. Johnson stated that she checked the extension of the showerhead and found that it could not reach the toilet. She also examined R2's head after he made the accusation.

¶ 51 Ms. Johnson confirmed that on April 25, she did not report R2's allegation to anyone at Pine Terrace or to the Department, nor did she make a written report of it. On April 26, she spoke with Ms. Grahame about the incident, after R2 made his allegation to staff at Northpointe.

¶ 52 Ms. Johnson described R2 as being "pretty crabby most of the time," and that he did not like to be bothered and liked to be left alone. According to Ms. Johnson, "for no apparent reason [R2] would just walk by you and say: I'm going to get you fired," and he would frequently say that to her and would swear at her "a lot."

¶ 53 B. Post-Hearing

¶ 54 On January 24, 2014, the administrative law judge issued a Report and Recommendation which the Department adopted and incorporated in full into its final order issued that same day. The Department's final order dismissed two of the seven initially-cited violations, affirmed four violations, reduced a fifth violation from "Type A" to a "Type B," and affirmed the issuance of Pine Terrace's Conditional License. The order additionally reduced the amount of the fine to $20,000, though no explanation was provided as to how this figure was reached. Pine Terrace sought administrative review of the Department's final order in the circuit court.

¶ 55 On February 9, 2015, the circuit court reversed the Department's order as to one violation and affirmed as to the remaining four violations. The circuit court then remanded the case "for adjustments of the penalties against [Pine Terrace] given the partial reversal." The Department subsequently issued an amended final order on July 17, 2015, which reflected the circuit court's reversal of the one violation but, without explanation, made no corresponding change to the fine imposed on Pine Terrace. Pine Terrace again sought administrative review in the circuit court.

¶ 56 Noting that "[t]he sole issue on remand was the adjustment of the penalties assessed against [Pine Terrace]," on February 22, 2016, the circuit court ordered the fine against Pine Terrace be reduced by $4,000. The court noted that the $20,000 fine originally assessed was "based on [Pine Terrace's] violation of five different sections (i.e. $4,000 per violation)." Because it had reversed the Department's finding as to one of the violations, the court explained, the fine "should have been based on four violations, not five, and the fine on remand should have reflected this, or at least reasons [should have been] given for not having done so." The court found the Department's decision to impose the same fine despite the partial reversal was "arbitrary and capricious and cannot stand," and remanded the case for the reduction of the fine in accordance with the court's order. Pine Terrace filed its notice of appeal from the circuit court's orders on March 21, 2016.

¶ 57 JURISDICTION

¶ 58 We have jurisdiction to review the circuit court's judgment under section 3-112 of the Code of Civil Procedure governing administrative review (735 ILCS 5/3-112 (West 2014)) and pursuant to Illinois Supreme Court Rules 301 and 303 governing appeals from final judgments entered below (Ill. S. Ct. R. 301 (eff. Feb. 1, 1994); R. 303 (eff. May 30, 2008)).

¶ 59 ANALYSIS

¶ 60 On appeal, Pine Terrace challenges the four violations of the Code upheld by the circuit court. It contends that the court's rulings in connection with those violations were an abuse of discretion, clearly erroneous, and against the manifest weight of the evidence. We address each violation separately.

¶ 61 The reviewing court's role in administrative cases is to review the decision of the administrative agency, not the determination of the circuit court. *Marconi v. Chicago Heights*

Police Pension Board, 225 Ill. 2d 497, 531 (2006). The applicable standard of review depends on whether the question presented is a question of fact, a question of law, or a mixed question of law and fact. *Id.* at 532. An agency's findings and conclusions on questions of fact are considered *prima facie* true and correct and are not to be reweighed by a reviewing court. *Beggs v. Board of Education of Murphysboro Community Unit School District No. 186*, 2016 IL 120236, ¶ 50. Factual determinations are to be reversed only if they are against the manifest weight of the evidence, which is the case "if the opposite conclusion is clearly evident." *Id.* In contrast, questions of law are reviewed *de novo*. *Wade v. City of North Chicago Police Pension Board*, 226 Ill. 2d 485, 505 (2007). An agency's decision is reviewed for clear error when it involves a mixed question of law and fact. This standard applies where the facts are admitted or established, the rule of law is undisputed, and the issue is only whether the facts satisfy the statutory standard. *Exelon Corp. v. Department of Revenue*, 234 Ill. 2d 266, 273 (2009). "An administrative decision is clearly erroneous when the reviewing court is left with the definite and firm conviction that a mistake has been committed." *Id.*

¶ 62 A. Section 350.1220(j) of the Code

¶ 63 Pine Terrace first argues that the circuit court erred in upholding the Department's finding that Pine Terrace violated section 350.1220(j) of the Code (77 Ill. Adm. Code 350.1220(j) (1999)) in its care of R4. This provision provides that:

> "The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days." 77 Ill. Adm. Code 350.1220(j) (1999).

The Department ruled in this case that this was a "Type A Violation," defined as one that:

> "creates a condition or occurrence relating to the operation and maintenance of a facility that creates a substantial probability that the risk of death or serious mental or physical harm to a resident will result therefrom or has resulted in actual physical or mental harm to a resident." 77 Ill. Adm. Code 300.330 (2006).

¶ 64 In concluding that Pine Terrace violated section 350.1220(j) of the Code, the administrative law judge, in her Report and Recommendation, stated that Pine Terrace staff did not have R4 see his physician "in every instance when conditions warranting physician care arose." The Report and Recommendation stated that that:

> "[A]fter being diagnosed with pneumonia, [R4's] condition was never fully relieved by doses of antibiotics, as noted by subsequent high temperature readings, fever, chills and signs of fatigue. No evidence was presented that R4's primary care physician, or his staff was ever advised of R4's persistent condition. R4 was only seen by his primary physician on March 22, 2010, for the principal purpose of securing a return to work order. Per the Physician Assistant, neither she nor the physician was contacted about R4's symptoms after the March 22, 2010 visit. This is true despite the fact [that] symptoms common to those produced by pneumonia occurred after [R4 was] seen at the physician's office and the fact that R4's temperature exceeded the threshold level identified by hospital physicians as warranting a revisit."

¶ 65 Pine Terrace's primary argument is that the symptoms that R4 experienced between March 22, when he visited his physician's office for permission to return to Lakeside, and March 28, when he was hospitalized, were characterized by the Department as "persistent" symptoms of

his illness and were therefore not an "accident, injury, or change in a resident's condition," that could sustain a finding of a violation of section 350.1220(j) of the Code. This argument presents a mixed question of fact requiring review under the "clearly erroneous" standard. Accordingly, we will reverse only if we are "left with the definite and firm conviction that a mistake has been committed." *Exelon*, 234 Ill. 2d at 273.

¶ 66 When R4 was discharged from the hospital with a diagnosis of pneumonia, he was perceived to be on the road to recovery. R4 received discharge instructions that required a physician to be notified if he had a fever of over 101 degrees that was not relieved by medicine, if he continued to have a fever after two to four days of treatment, if he coughed up smelly or blood-tinged sputum, if he developed shortness of breath or chest pain, if he did not improve in three to five days, or if he seemed to be getting worse and not better. It is apparent from these discharge instructions that any of these occurrences would indicate that R4 was not recovering in the manner that was expected.

¶ 67 The evidence presented at the administrative hearing demonstrated that, pursuant to these discharge instructions, R4's condition on at least three occasions required a physician to be notified. When the signs that R4 was not recovering outlined in the discharge instructions presented, R4's condition had, indeed, changed and section 350.1220(j) of the Code required Pine Terrace to notify R4's physician.

¶ 68 The first instance that a physician should have been notified was when he returned to Lakeside on March 24, five days after R4 began taking antibiotics for his pneumonia. Staff at Lakeside found R4 to be "[l]ethargic, very tired, very quiet, [and he] refused to engage." That evening, at Pine Terrace, R4 had a fever of 101.3 degrees, and staff responded by administering

Tylenol. There is no indication that R4's physician's office was ever contacted about his condition that day.

¶ 69 On the morning of March 26, seven days after he began antibiotics, R4 was at Lakeside and he was "was very lethargic, very tired, coughing," and moaning, and he kept his head down on his desk. His temperature was measured to be 99.5 degrees. He was not brought back to Pine Terrace due to the unavailability of transportation, and his symptoms purportedly subsided in the afternoon. The physician's assistant specifically told Mr. Troop that the physician's office was not made aware of R4's condition that day.

¶ 70 On March 28, nine days after he began antibiotics, R4 was given Tylenol and Robitussin in the morning for fever and cough and, instead of coming out for lunch, he stayed in bed. He had a "painful cough" at 1 p.m., was given additional medication for that, and stayed under his covers all day until staff noticed that "he was in a state of distress" when they checked on him at 8 p.m. At that point, staff brought him to the hospital. Neither the nurse consultant nor the physician's office was notified of R4's condition any time during that day and no doctor was notified about R4's condition until he was brought to the hospital late that evening. Even at that point, R4's own physician was not notified. Section 350.1220(j) of the Code does not simply require the facility to take an ailing resident to a hospital, or to contact *any* physician, but requires the facility to "notify *the resident's* physician" of a change in condition that threatens his health or welfare. (Emphasis added.) 77 Ill. Adm. Code 350.1220(j) (1999). Pine Terrace failed to do so here, even after the evidence showed that R4 was in such a state of distress that he required hospitalization.

¶ 71 Pine Terrace notes that R4 "never had a 'continuous' fever" and on March 22, for example, the only occasion he saw the physician's assistant during this period, his condition had

improved. However, as described above, there were also periods, more than two days after he had begun treatment, when R4's condition was significantly worse—when he had a fever, was particularly lethargic, had a painful cough, was moaning, and refused meals.

¶ 72 Pine Terrace argues that R4's condition did not require a return visit to the doctor under the discharge instructions because he never had a continuous fever or a fever of over 101 degrees that did not respond to medication and that he did improve at various points after he was discharged. However, the discharge instructions were that a doctor should be alerted if R4 had a fever after two to four days or if he was not improving in three to five days. The evidence showed that R4 did have fever more than four days after discharge and that, while he had periods when he appeared to be improving, there were signs that he was not improving on March 24, March 26, and March 28. The Department did not clearly err in finding that R4's lapses in recovery from pneumonia after his hospitalization constituted changes in his condition obligating Pine Terrace to notify R4's physician under the Code.

¶ 73 Pine Terrace also argues that there was no evidence to support the Department's finding that R4's physician and his staff were not advised of R4's condition and thus the Department's finding is against the manifest weight of the evidence. Pine Terrace points to evidence that R4 was evaluated by the physician's assistant on March 22 and claims that his physician was notified of his change in condition on March 28. The fact that R4 was seen by the physician's assistant on March 22 did not relieve Pine Terrace of its obligation to notify R4's physician when his condition subsequently worsened on March 24 and March 26. Moreover, as discussed above, on March 28, no physician was notified about R4's change in condition that occurred mid-day until he was taken to the hospital around 8 p.m. and, even then, R4's own physician was never

notified of his change in condition. Pine Terrace cites no evidence rebutting these findings, which we conclude are not against the manifest weight of the evidence.

¶ 74 We reject Pine Terrace's contention that Mr. Troop was unqualified to give testimony regarding the need to notify R4's physician of any change in R4's condition because he lacked necessary training and had no firsthand knowledge of the relevant facts, instead basing his opinion on interviews and his review of the records. It is apparent from the record that the administrative law judge did not rely on Mr. Troop's opinion to make her determination. Nor was Mr. Troop's opinion, as Pine Terrace insists, "the only evidence to suggest that R4's condition required additional physician notification." We have discussed the evidence that supports the administrative law judge's determination in some detail.

¶ 75 Pine Terrace also argues that the administrative finding that section 350.1220(j) of the Code was violated is essentially a conclusion that Pine Terrace did not provide adequate care for R4. As Pine Terrace notes, the Code requires facilities to "provide all services necessary to maintain each resident in good physical health" (77 Ill. Adm. Code 350.1210 (1989)), and the administrative law judge found that a violation of that provision was not established. We reject Pine Terrace's unsupported contention that the established violation of section 350.1220(j) was a " 'make-up' violation for unrelated conduct." Nothing in the record indicates that the administrative law judge based her finding on anything but the requirements of that section, which are different from those of section 350.1210 of the Code. In sum, we find no basis for overturning the Department's finding that there was a violation of section 350.1220(j) of the Code.

¶ 76 B. Section 350.3750 of the Code

¶ 77 Pine Terrace next argues that the circuit court erred in upholding the Department's finding that Pine Terrace violated section 350.3750 of the Code (77 Ill. Adm. Code 350.3750 (1995)) in its care of R4. This portion of the Code provides that:

> "Residents needing nursing care shall be admitted to an ICF/DD [Intermediate Care Facility for persons with Developmental Disabilities] of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies [cite]. The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month." 77 Ill. Adm. Code 350.3750 (1995).

The Department's Final Order found that this was a "Type A Violation" (77 Ill. Adm. Code 300.330 (2006)).

¶ 78 In her Report and Recommendation, the administrative law judge noted that Nurse Helfrich, the nurse under contract, gave inconsistent testimony regarding how often she provided "in person" consultations with residents at the facility, and found her testimony to be "incredible." Although Nurse Helfrich stated that she met with residents on a monthly basis and met specifically with R4 twice per month, she never saw R4 after February 11, 2010, and never personally examined him during the period he suffered from pneumonia. Her reports and treatment recommendations were based purely on communications with Pine Terrace staff,

"despite reports of R4's experiencing high temperature readings, bouts of fever, and lethargic behavior warranting physician service visits."

¶ 79 Pine Terrace argues that section 350.3750 of the Code does not allow the Department to determine the adequacy of nursing services provided for residents, but rather only provides that "[r]esidents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs." Thus, according to Pine Terrace, the only inquiry as to the adequacy of nursing care is made at the time of admission and there was no evidence presented as to what care was provided at the time that R4 was admitted to Pine Terrace. In reference to ongoing care, Pine Terrace argues that the nurse must be contracted to visit the facility, to provide consultation on the residents' plans of care, and to "be in the facility not less than two hours per month." Pine Terrace contends that this is the only requirement and it was met.

¶ 80 As a threshold issue, the Department contends that Pine Terrace waived this argument because it did not raise it during the administrative proceedings. We disagree. As the Department notes, our supreme court has made it clear that "*issues* or *defenses* not placed before the administrative agency will not be considered for the first time on administrative review." (Emphasis added.) *Texaco-Cities Service Pipeline Co. v. McGaw*, 182 Ill. 2d 262, 278 (1998). However, the Department does not assert that Pine Terrace has presented a new issue or defense. Pine Terrace is not precluded from making an argument for the first time on appeal. *Brunton v. Kruger*, 2015 IL 117663, ¶ 76 ("We require parties to preserve issues or claims for appeal; we do not require them to limit their arguments here to the same arguments that were made below.").

¶ 81 As to the merits of Pine Terrace's argument, we find the administrative law judge's conclusion that the Department proved a violation of this provision was not clearly erroneous or

against the manifest weight of the evidence. We reject Pine Terrace's suggestion that this regulation only requires that the consulting nurse visit two hours per month. We also find that, even if that were the only requirement, it would not have been against the manifest weight of the evidence for the Department to conclude that this requirement was not met.

¶ 82 Pine Terrace is correct that the Report and Recommendation, in which the administrative law judge bolded the words "adequate nursing services" in the first sentence of the regulation, focused on that sentence which appears directed to the adequacy of a facility's nursing services at the time of admission. But section 350.3750 of the Code also provides that "[a]rrangements shall be made through formal contract for the services of a licensed nurse to visit *as required*." (Emphasis added). 77 Ill. Adm. Code 350.3750 (1995). Thus, the regulation also mandates that a facility provide ongoing nursing services, as those services are "required." The arrangement between Pine Terrace and Nurse Helfrich allowed for the vast majority of all evaluations to be done remotely, based on communications with and reports from Pine Terrace staff regarding the residents' conditions, where the resident was not personally examined by the nurse. As the administrative law judge noted in her Report and Recommendation, "despite reports of R4's experiencing high temperature readings, bouts of fever, and lethargic behavior warranting physician service visits," and knowing that R4 had been diagnosed with pneumonia, the nurse consultant never personally examined him. It was not clearly erroneous to find that this level of nursing care violated section 350.3750 of the Code.

¶ 83 The evidence also supported a finding that Nurse Helfrich was not in the facility for at least two hours per month, as section 350.3750 of the Code explicitly requires. Pine Terrace argues that, in reaching this conclusion, the Department "impermissibly flipped the burden of proof onto Pine Terrace." Pine Terrace contends no evidence clearly established this and that no

records were put into evidence as to Nurse Helfrich's possible visits with other patients during that time. However, as the administrative law judge noted, Nurse Helfrich provided conflicting testimony regarding how often she frequented each facility to see residents. Although she asserted at one point that she met with residents on a monthly basis or more frequently than that, she did not recall ever visiting Pine Terrace during March 2010. Her testimony was further undermined by her records, which indicated that she never saw R4 after February 11, 2010, including through the entirety of his illness. The administrative law judge found that Nurse Helfrich "admitted" that she did not visit Pine Terrace at all during March 2010. As the finder of fact, the administrative law judge was entitled to view Nurse Helfrich's response of "[n]ot that I can specifically recall" to the question of whether she ever visited Pine Terrace during March 2010 as an admission that she never did so, and we are compelled to accept the Department's weighing of the evidence and credibility determinations where there is a question of fact (*Crittenden v. Cook County Commission on Human Rights*, 2012 IL App (1st) 112437, ¶ 43). The finding here was not against the manifest weight of the evidence.

¶ 84 C. Section 350.3240(a) of the Code

¶ 85 Pine Terrace argues that the circuit court erred in upholding the Department's finding that Pine Terrace violated section 350.3240(a) of the Code (77 Ill. Adm. Code 350.3240(a) (1991)) in the incident involving R2. This portion of the Code provides that:

> "An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident." 77 Ill. Adm. Code 350.3240(a) (1991).

¶ 86 In concluding that Pine Terrace violated section 350.3240(a) of the Code, the administrative law judge noted in her Report and Recommendation that R2's functional level was "the equivalent of a five year and three month old child," and stated that:

> "despite the testimony introduced by [Pine Terrace] that R2 had a history of intentionally or falsely accusing staff, it is doubtful that R2 is capable of forming the 'mens rea' or intent to formulate a plan to facilitate the firing of an employee and to carry it out. Whereas, [Ms. Johnson] possessed the capability and motivation to plot and mislead. Her testimony was incredible, biased and clearly delivered in such a manner to preserve her employment and to exonerate her employer."

The Report and Recommendation also stated that Ms. Grahame's findings with respect to the retraction of R2's claim were "suspect":

> "The fact that R2 was questioned without the benefit of family or other advocate being present raises concerns of intimidation. It is uncontroverted that R2 had the characteristics of a child victim. His interrogation should have been handled with protections freely given without the threat of fear or intimidation."

The administrative law judge found that "the persistence and consistency of [the] story told by R2 up until the time of his interview with the facility staff [was] compelling" and concluded that Pine Terrace failed to protect R2 from abuse.

¶ 87 The administrative law judge then determined that a Type A Violation had not been established, as there was insufficient evidence that the alleged abuse created a substantial probability that R2 would suffer death or serious mental or physical harm. She noted that, in determining the level of violation, the Department must consider (1) whether the resident can recognize potentially harmful conditions and take measures to protect himself, and (2) whether and how much actual harm to the resident resulted from the condition or occurrence. The administrative law judge found that there was no physical or medical evidence of injury, and she

noted that R2 could not read or write and his functional level was that of a five-year-old child. For those reasons, the Report and Recommendation stated that, instead, a "Type B Violation" had been established, one that:

> "creates a condition or occurrence relating to the operation and maintenance of a facility that is more likely than not to cause more than minimal physical or mental harm to a resident." 77 Ill. Adm. Code 300.330 (2006).

¶ 88 Pine Terrace argues that the finding that it violated section 350.3240(a) of the Code was "against the manifest weight of the evidence, legally erroneous, and an abuse of discretion." It first contends that "[n]o witness testimony, physical evidence, or circumstantial evidence support[ed] a finding of abuse." Pine Terrace claims that the Department ignored all of the evidence that showed that Pine Terrace staff never abused R2, including the first-hand account from Ms. Johnson, the other Pine Terrace staff member present during the alleged abuse, that she did not see any abuse; the "physical impossibility" of the showerhead reaching R2 while he was sitting on the toilet; the lack of any sign of physical injury to R2; and R2's prior tendencies to make false accusations against staff. Pine Terrace argues that the only evidence that supported the Department's findings was R2's allegations, which were "inconsistent and recanted."

¶ 89 Pine Terrace contends that the Department improperly discounted the testimony of Ms. Grahame and Ms. Johnson where it did not "identify[ ] what testimony [was] not credible and what evidence undermine[d] the testimony," and that the testimony of these witnesses was ignored "apparently for the sole reason that they [were] Pine Terrace employees."

¶ 90 We disagree. The administrative law judge provided a clear explanation for how she weighed all of the testimony: Ms. Johnson's testimony "was incredible, biased and clearly delivered in such a manner to preserve her employment and to exonerate her employer," and

there were "concerns of intimidation" in the way Ms. Grahame confronted R2 which made her findings suspect with respect to the retraction of his allegations. The finder of fact is "in the best position to observe the conduct and demeanor of the witnesses and to assess the evidence based on its observations" (*In re Diane L.*, 343 Ill. App. 3d 419, 425 (2003)), and there is no basis to overturn the administrative law judge's assessment of the testimony here.

¶ 91 The Department's determination that R2 was actually hit by Mr. Goodenough with the showerhead is a finding of fact that we will reverse only if it is against the manifest weight of the evidence, which is the case "if the opposite conclusion is clearly evident." *Beggs*, 2016 IL 120236, ¶ 50. It is not the role of this court to reweigh the Department's findings and conclusions on questions of fact. *Id.* "If the record contains evidence to support the agency's decision, that decision should be affirmed." *Marconi*, 225 Ill. 2d at 534. We find that to be the case here.

¶ 92 On multiple occasions and to different individuals, R2 made the allegation that Mr. Goodenough struck him with a showerhead. Although R2 did not personally testify at the hearing, there was sufficient evidence presented of his allegations of abuse to allow the administrative law judge to weigh the evidence and to support her finding that R2's version of events was "compelling" despite the evidence Pine Terrace offered to the contrary. The circumstantial and testimonial evidence Pine Terrace presented in an attempt to prove that R2 could not have been hit with the showerhead was not so persuasive that it required the finding that R2's allegations were not true.

¶ 93 Pine Terrace argues that the Department's finding of a violation is "legally erroneous" because the administrative law judge relied on her finding that R2 did not likely possess the *mens rea* to lie about being abused. Pine Terrace asserts that, not only was this finding rebutted by evidence that R2 had a history of making false accusations against the staff, but the finding was

not supported by any evidentiary basis, where R2 was never called as a witness and no evidence was introduced about his capacity to maintain a particular mental state.

¶ 94 Although no evidence directly addressed R2's *mens rea* capacity, the evidence about R2's allegations, when he made those allegations and to whom he made them, how the staff responded to those allegations and how they questioned him, and the circumstances surrounding R2's responses to being questioned by staff, may all be considered in light of other evidence about R2 that was presented at the hearing, such as his functional ability and development level. It is the role of the finder of fact to draw conclusions based on all of the evidence, and it is not apparent that the administrative law judge based her factual findings on anything other than the evidence that was presented at the hearing.

¶ 95 Nor do we find compelling Pine Terrace's argument that it was an abuse of discretion for the administrative law judge to reject R2's recantation of his allegation in part on the basis that Ms. Grahame acted improperly by interviewing R2 about his allegations without any family or other advocate being present, even though there is no requirement in the Code for conducting an investigation in this manner, while crediting the accusations that R2 made during his interview at Northpointe even though he similarly lacked any family or advocate support. This is a false comparison. When R2 was questioned by Ms. Grahame, he was alone with her and one other Pine Terrace manager; R2 was told that two staff members had denied that the incident happened, and Ms. Grahame "asked him about the incident, explain[ed] that no one had seen anything, no one was aware of any incident, and asked him if this really did happen to him." The administrative law judge found this questioning of R2 to raise "concerns of intimidation." In contrast, there was no evidence to suggest that there were any concerns of intimidation involved when R2 made his allegations to staff at Northpointe, and we see no reason to find the

administrative law judge's crediting what R2 said in one situation and not in the other to be improper. We do not agree with Pine Terrace's assertions that the Department employed a "selective reading of the record" or that its conclusion was based on "gross speculation" and "influenced by extraneous considerations."

¶ 96 D. Section 350.3240(b) of the Code

¶ 97 Finally, Pine Terrace argues that the circuit court erred in upholding the Department's finding that Pine Terrace violated section 350.3240(b) of the Code (77 Ill. Adm. Code 350.3240(b) (1991)) in the incident involving R2. This provision provides that:

> "A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator." 77 Ill. Adm. Code 350.3240(b) (1991).

The Department found that this was a "Type A Violation" (77 Ill. Adm. Code 300.330 (2006)).

¶ 98 In concluding that Pine Terrace violated section 350.3240(b) of the Code, the administrative law judge noted in her Report and Recommendation that on April 25, 2010, after R2 told Ms. Johnson that Mr. Goodenough had just hit him with the showerhead, Ms. Johnson did not notify anyone about R2's allegation that day because she did not believe him to be serious. According to Ms. Grahame, Ms. Johnson did not report the incident to management until Ms. Grahame interviewed her about the incident several days later. R2's subsequent "retraction" of his allegation did not eliminate the requirement for Ms. Johnson to report the incident; according to the Report and Recommendation, the regulation "does not allow for discretion in reporting resident accounts of abuse."

¶ 99 Pine Terrace first argues that section 350.3240(b) of the Code "requires employees to report abuse or neglect," but, because no abuse actually occurred, this reporting requirement was

never triggered. According to Pine Terrace, this provision does not apply to "accounts" or "allegations" of abuse, only to awareness of actual abuse, and Ms. Johnson was not aware of any actual abuse. In its Reply Brief, Pine Terrace argues that, even if Ms. Johnson was required to report allegations of abuse where she has "reasonable cause" to believe abuse occurred, she did not have reasonable cause to believe that to be the case here.

¶ 100 As the Department correctly notes, under section 350.3240(b) of the Code, if an employee has "reasonable cause" to believe a resident had been subjected to abuse, that employee is required to immediately report the matter. See *Alden Nursing Center-Morrow, Inc. v. Lumpkin*, 259 Ill. App. 3d 1027, 1033-34 (1994) (interpreting effectively identical language in the Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300.3240(b) (1991)). We reject any contention by Pine Terrace that the Code requires knowledge that a resident has definitely been abused before an employee is obligated to report or that, "[w]ithout an underlying instance of abuse to report, there can be no violation of Section 350.3240(b)." A violation of this provision is based on whether an employee had reasonable cause to believe a resident was abused, which is a separate question from whether abuse actually occurred. Where there was reasonable cause to believe a resident's allegation of abuse at the time that allegation was made, a subsequent investigation that establishes that no abuse actually occurred does not retrospectively negate a violation of section 350.2340(b) of the Code.

¶ 101 We will reverse the finding that a violation was established only if we are "left with the definite and firm conviction" that Ms. Johnson did not have reasonable cause to believe R2's allegation that he was abused. *Exelon*, 234 Ill. 2d at 273. Here, where R2 specifically told Ms. Johnson that he had been hit by Mr. Goodenough, there was evidence to support a finding that

section 350.3240(b) of the Code was violated and the decision of the administrative law judge was not clearly erroneous.

¶ 102 Pine Terrace argues that, under the "reasonable cause" standard, facility employees are not required to report any and all allegations of abuse to facility administrators, no matter how groundless. We agree. As employees do have this discretion in reporting allegations of abuse, Pine Terrace argues that the administrative law judge's statement that the regulation "does not allow for discretion in reporting resident accounts of abuse" was "legally erroneous" and her determination that this violation was established should therefore be vacated.

¶ 103 We do not agree with Pine Terrace's interpretation of the administrative law judge's Report and Recommendation. Her statement that an employee does not have discretion in reporting resident accounts of abuse was made in the context of rejecting Pine Terrace's argument that R2's subsequent retraction of his allegation eliminated any requirement to report. The administrative law judge correctly noted that a subsequent retraction of the allegation would not eliminate an employee's obligation to comply with section 350.3240(b) of the Code or give the employee discretion not to report that abuse, if there was reasonable cause to believe it occurred. *Lumpkin*, 259 Ill. App. 3d at 1033-34. Although the administrative law judge did not recite the *Lumpkin* "reasonable cause" standard, her Report and Recommendation does not suggest that she misapplied the relevant law.

¶ 104 CONCLUSION

¶ 105 For the foregoing reasons, we confirm the decision of the administrative agency, as modified by the reduction in fine imposed by the circuit court.

¶ 106 Affirmed.