

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/08/2025
NAME OF PROVIDER OR SUPPLIER Landmark of Richton Park Rehab & Nsg Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 22660 South Cicero Avenue Richton Park, IL 60471	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based upon interview and record review the facility failed to follow policy procedures, failed to implement care plan interventions, and failed to notify the physician and responsible party regarding critical blood glucose levels for two of four residents (R1, R2) reviewed for change in condition. Findings include: On 8/21/25, IDPH (Illinois Department of Public Health) received allegations that facility staff refused to contact a doctor when resident blood sugars were elevated. R1's diagnoses include type II diabetes mellitus. V3 (Family) is listed as the emergency contact on R1's face sheet. R1's (6/5/24) care plan interventions state report abnormal blood sugars to Medical Doctor. R1's (June 2024) MAR (Medication Administration Record) affirms blood glucose levels were (critical) high on the following dates: 6/1: 413. 6/7: 432. 6/15: 500. 6/18: 419. 6/20: 469. 6/23: 450. 6/24: 430. 6/27: 419. R1's (June 2024) Nurses Notes exclude (critical) high blood glucose levels and physician/responsible party notification of resident change in condition. On 9/4/25 at 2:20pm, surveyor inquired if there was any documentation in R1's EMR (Electronic Medical Records) regarding notification for R1's (6/15/24) critical blood glucose level of 500 - per MAR V2 (DON/Director of Nursing) reviewed R1's EMR and stated No, there's no documentation that she (Nurse) called the Physician or Nurse Practitioner for the 15th. Surveyor inquired if there was any documentation that R1's Physician and/or Family were notified for any of R1's (June 2024) critical blood glucose levels V2 reviewed the EMR to no avail and affirmed that notification was not documented. __R2's diagnoses include diabetes mellitus with hyperglycemia. V9 (Family) is listed as the emergency contact on R2's face sheet. R2's (11/7/18) care plan interventions state monitor for signs/symptoms of hyperglycemia, report to Nurse and Physician as needed. R2's (9/2/25) MAR affirms blood glucose level was 486 (at 5:00pm) and 9 (see nurse note) was documented. R2's blood glucose level was 400 (at 9:00pm) and 9 was documented. R2's (9/2/25) Medication Administration Note states (10:33pm), medicated with 25units Lispro insulin for blood sugar of 486 per Nurse Practitioner (V7). (10:40pm), Medicated with 10 units Lispro insulin per Nurse Practitioner (V7). [Family notification was excluded]. On 9/4/25 at 3:23pm, surveyor inquired if V7 (Nurse Practitioner) or Physician were notified (on 9/2/25) of R2's critical blood glucose levels at 5pm and 9pm V5 (Registered Nurse) stated I called her (V7) twice (at 5pm and a half hour later) and during the 9pm, I didn't call her then affirmed that the (9/2/25) Medication Administration Notes were referring to (5pm) insulin administrations - however entered later in the shift. The (6/9/25) facility guidelines for notification of change in resident's condition/status/treatment states notification is provided to the physician to facilitate continuity of care and to obtain input from the physician about appropriate interventions/changes which can include additions to, or discontinuation of, current care/treatments - related to the notification. Notification is provided to the resident's responsible party/POA (Power of Attorney). Requirements for notification of resident, their attending physician, and the residents responsible party/POA: a significant change in the resident's physical, mental, or psychosocial status. A significant change includes deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. Document the notifications and record any new orders received from the physician in the resident's medical record. When a change of condition occurs - the nurse will perform an appropriate assessment of the resident as well as then making the required notifications. The assessment and the notifications will be documented. Examples of situations/circumstances when the physician must be immediately notified: any critical lab value.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and record review the facility failed to follow policy procedures, failed to implement care plan interventions, failed to obtain physician orders for blood glucose monitoring/sliding scale insulin, failed to receive blood glucose parameters for physician notification, failed to follow physician orders, failed to ensure that medication was administered/documented within regulatory requirements, and/or failed to ensure that (critical) blood glucose levels were addressed by a physician/nurse practitioner for two of four residents reviewed for change in condition. These failures resulted in R1 sustaining critical blood glucose levels ranging from 413-500 (without intervention) for a total of 8 days within 1 month. These failures also resulted in R2 sustaining a critical blood glucose level of 400 (without prescribed sliding scale insulin) for 11 hours. Findings include: On 8/21/25, IDPH (Illinois Department of Public Health) received neglect allegations due to facility staff refusing to contact a doctor when resident blood sugars were elevated. R1 was admitted to the facility on [DATE] with diagnoses which include but not limited to morbid obesity due to excess calories and type II diabetes mellitus. R1 was discharged on 7/2/24 (prior to this survey). R1's (6/5/24) care plan includes potential for complications of metabolic functioning as evidenced by hyper/hypoglycemia, interventions: monitor blood sugars as ordered and cover as ordered per sliding scale. Report abnormal blood sugars to Medical Doctor. R1's (6/1/24) POS (Physician Order Sheets) include check blood glucose before each meal and at bedtime [parameters for physician notification are excluded]. Glargine (insulin) inject 85 units every morning and at bedtime. Humalog (Insulin) inject 50 units before meals. [Sliding scale insulin is excluded]. On 9/3/25 at 1:19pm, surveyor inquired if any residents were recently sent out to the hospital due to blood sugar concerns V2 (DON/Director of Nursing) stated We haven't had anybody go out for hyperglycemia or hypoglycemia recently, not that I'm aware of. Surveyor inquired if any residents or family members recently reported concerns regarding blood sugars V2 responded No. Surveyor inquired when R1 was discharged from the facility V2 replied He (R1) has been gone a while, he discharged I wanna say back in 2024. He (R1) was short term stay; I (V2) don't believe he was sent out for blood sugar. I (V2) do remember him (R1) having issues with his blood sugar because the wife (V3) was bringing in all the wrong foods. She (V3/Wife) brought him (R1) whatever he wanted, and we (staff) had to have a meeting with her (V3) about it. She was educated on his diet. We (staff) also found out that she (V3) was giving insulin to him when she was here, and we have that care planned. R1's progress notes state (6/2/24) 9:22am, upon entering resident room, writer noted resident wife with a filled syringe in her hand about to administer it to resident but stopped when I entered the room. Writer made appropriate parties aware [R1's 6/2/24 blood glucose was 330 at 7:30am and 339 at 11am per MAR/Medication Administration Record]. (6/5/24) 3:47pm, Staff reports resident's wife was observed with a vial of insulin to administer to the resident [R1's 6/5/24 blood glucose was 202 at 4pm per MAR]. R1's (June 2024) MAR also affirms that blood glucose levels were (critical) high on the following dates: 6/1: 413. 6/7: 432. 6/15: 500. 6/18: 419. 6/20: 469. 6/23: 450. 6/27: 419 however R1's (June 2024) Nurses Notes exclude critical high blood glucose levels and physician notification of resident change in condition. On 9/4/25 at 1:01pm, surveyor inquired about resident blood glucose monitoring V6 (Medical Director) stated, If someone's uncontrolled we (staff) would probably be checking that with meals. Surveyor inquired what parameters should be inclusive for hyperglycemia V6 responded We have about 3 different options; it would be 350 or 400. Surveyor inquired about staff requirements if a resident's blood glucose is 400 or above V6 replied It should be whatever the order is [R1's Physician orders exclude sliding scale insulin] and affirmed the physician should be contacted. Surveyor inquired about potential harm to a resident with a blood glucose level that's 400 or above V6 stated Medical comorbid conditions associated with hyperglycemia which could be infection, DKA (Diabetic Ketoacidosis), or hyperosmolality. On 9/4/25 at 2:20pm, surveyor inquired if there was any documentation in R1's EMR (Electronic Medical Records) regarding notification for R1's (6/15/24) critical blood glucose level of 500 - per MAR V2 (DON/Director of Nursing) reviewed R1's EMR and stated No, there's no documentation that she (Nurse) called the Physician or Nurse Practitioner for the 15th. Surveyor inquired if there was any documentation that R1's Physician was notified for any of R1's (June 2024) critical blood glucose levels V2 reviewed the EMR to no avail and responded They (staff) were giving the insulin that was ordered but nobody thought about a sliding scale. He (R1) had no sliding scale the entire time he was here, everybody missed it [R1 resided at the facility for over 1 month]. R2's diagnoses include diabetes mellitus with hyperglycemia however the (9/3/25) facility</p>		