STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145424	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Richton Park Rehab & Nsg Ctr	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, the facility failed to ensure the call light was within reach and working properly for R2 who was diagnosed with a tracheostomy and uses a communication board for 1 of 3 (R2) residents reviewed for accommodation of needs in a total sample size of twelve. Findings Include:R2 was diagnosed with Acute Respiratory Failure with Hypoxia, Tracheostomy and Hemiplegia affecting the left non-dominant side. Minimal data set section B (hearing, speech and vision) dated 10/6/25 documents: Persistent vegetative state/no discernible consciousness. No. Speech Clarity: No speech. Care plan dated 11/11/25 documents: R2 uses the following appliances: Communication board, card or writing pad/board. On 12/3/25 at 1:11PM, R2's call light string was observed hanging from the wall, on the floor, with the pull switch in a down position. R2 could not reach the call light. R2's call light did not illuminate above his room or make an audible sound. Surveyor checked the call light on the panel behind the nursing station. R2's call light did not display an indication/notification light on the panel. V9 (unit nurse) entered R2's room and clip the call light onto R2's clothing. R2 was asked how he communicate with staff. R2 pulled the call light string. The call light did not aluminate or make an audible noise. R2 who was assessed to be alert and oriented to person, place and time wrote, on his communication board that his call light has not worked in a week. On 12/3/25 at 1:18PM, V9 said, R2 call light switch was in the down position this morning when she checked on R2. V9 called V8 (Maintenance). V9 went into R2's bathroom and check that call switch with another staff member. V9 said, V8 told her to check the bathroom call light switch. V9 said, the bathroom switch was positioned in the middle.On 12/3/25 at 1:47PM, V8 said, R2's room call light won't work, if the bathroom call light is positioned in the middle. V8 said, he was unaware of how R2's call light got positioned in the middle position because R2 does not get up to use the bathroom.Guidelines for call lights dated 3/4/24 documents: It is the policy of the facility to have a system in place to allow the staff to respond promptly to a resident's call for assistance and to ensure that the call systems is in proper working order. Always be sure the resident has a function call light that is the easiest type for them to use. Always place the call light in an accessible location to where is located in their room.

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
	145424	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Richton Park Rehab & Nsg Ctr	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145424	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Richton Park Rehab & Nsg Ctr	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 0600 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 abuse policy by not ensuring R7 was free from verbal abuse by V18 (nurse). This failure resulted in V18 engaging in a loud verbal abusive argument resulting in R7 feeling threatened and belittled like a child. In addition, the facility neglected to ensure V18 provided care according to professional standard for R2 and R12 who had the diagnosis of Respiratory Failure with attention to Tracheostomy by not providing suctioning as needed. This neglect resulted in R2 having difficulty breathing. R12 having low oxygen saturation of eighty percent (88%). V18 also neglected to administer R6's nightly prescribed long-acting insulin as scheduled for 4 of 4 residents reviewed for abuse in a total sample size of 12. Findings include:On [DATE] at 11:44AM, R6 (R7's roommate) who was assessed to be alert and oriented to person, place and time said, V18 was yelling at R7. R6 said, V18 engaged in confrontational, loud, unprofessional argument with R6. On [DATE] at 1:27pm, R7 who was assessed to be alert and oriented to person place and time said, V18 (nurse) was verbally aggressive and combative when R7 wanted to go smoke prior to taking her evening medication. R7 said, she went outside to smoke and returned. R7 said, V18 came to her room at 10:00pm to administer medications. R7 said, V18 was argumentative, loud and verbally abusive without provocation. R7 said, V18 continued to call her another name despite being told R7's name. R7 said, V18 yelled at her about being impatient in the harshest threatening tone. R7 said, V18 snapped and she spoke to her like she was nobody, R7 said, V18 was yelling like she owned the facility, R7 was a child, and she felt threatened and belittled. On [DATE] at 2:53pm, V4 (nurse) said, when she arrived on the unit with her coat and bags, residents were asking for her to come to their rooms. V4 said, she told the resident to check with their current nurse because needs to get report first. V4 said, V18 started yelled at her without provocation. V4 said, V18 yelled at her and stated, she could not stand V4 and V4 got on her f****** nerves, and other abusive words included talking about V4's deceased parents at the nursing station. V4 said, R7 told her V18 was rude to her and called her out of her name. V4 said, R7 would not elaborate on the name calling. On [DATE] at 5:08pm, V2, Director or Nursing (DON) said, she was informed V18 demonstrated inappropriate nursing care. V2 said, V18 was terminated for conduct issues, being rude and discourteous behavior to staff and a family member. V2 said, if someone said, V18 did something, V18 did it. On [DATE] at 5:17pm, V1 (administrator) said, if a staff member was arguing loudly and being confrontational with a resident it is considered poor nursing and verbally abusive. Statement dated [DATE] document: R7 stated that V18 was rude to her and called her out of her name.R2 was diagnosed with acute and chronic respiratory failure with hypoxia and attention to tracheostomy. R2's care plan dated [DATE] documents: R2 is at risk for complication related to tracheostomy. Interventions: Daily trach care as needed. Monitor for secretions and suction as needed. R12 was diagnosed with respiratory failure with attention to tracheostomy. Requested for R12's care plan from facility. R12's care plan was not submitted during the survey.On [DATE] at 12:30PM, R2 was asked what happen with staff and his tracheostomy. R2 who was assessed to be alert and oriented to person, place and time wrote, he could not breathe, V18 did not suction his trach. R2 wrote, he started to panic. R2 wrote he tried to pull his call light, but it did not work. R2 wrote he may need suction once a day or less.On [DATE] at 2:53PM, V4 (nurse) said, R2 and R12 both reported V18 did not provide tracheostomy care. V4 said, she assessed both resident and tracheostomy care was not provided. V4 said, V18 was the assigned nurse. V4 said, R2 wrote, V18 did not suction his tracheostomy the entire shift. V4 said, R2 also wrote, that he pulled the call light, but it did not work. V4 said, R12 who could talk said, she could not breathe. V4 said, R12 reported that V18 did not suction her tracheostomy. V4 said, R12 oxygen saturation was eighty eight percent (88%) which was low. The normal levels are between 94-100%. Levels below 90% requires medical attention. V4 said, R12 no longer resides at the facility. V2 said, she was notified by V4 via text about V18 on the night she found the residents without care and wrote a statement after the holiday. Nursing note dated [DATE] documents: R2 in bed with eye opened, Alert and oriented x 2-3 Head of the bed was flat, Writer elevated the head of the bed and observed that the Trach area is messy and nasty, and full of secretion. R2 pointed at the trach site, Writer asked him to write it down because she could not understand what that means by pointing at the Trach area. R2 wrote down on the white board that he needs to be suctioned and has not been suctioned. R12 in bed with eye opened, alert and oriented times three. Head of the bed elevated. R12 stated that she is not feeling the oxygen coming through and has not been suctioned through the shift. Oxygenation checked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145424	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Richton Park Rehab & Nsg Ctr	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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145424	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Richton Park Rehab & Nsg Ctr	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 0686 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 treatment/services to prevent/heal pressure and non-pressure wounds policy for one resident (R3) with multiple pressure sores by not following physician recommendations/orders for wound treatments, failing to document treatments administered and failing to document weekly measurements/assessments of wounds for one of three residents reviewed for wound care. Findings include:R3's was admitted to the facility on [DATE] with a diagnosis of type II diabetes, protein malnutrition, dependance on ventilator, muscle wasting and anxiety.R3's plan of care dated 9/17/24 documents: R3 has an alteration in skin integrity and is at risk for additional and/or worsening of skin integrity issues related to: Impaired Cognition, Impaired Communication, Incontinence of bladder, Incontinence of bowel, Impaired Mobility Status, Impaired Nutritional Status, Diabetes, Comorbidities. Interventions include: Weekly measurements and documentation and Administer Wound Care (Treatments) per MD orders dated 9/17/24.R3 wound notes by V20 (wound MD) dated 7/31/25 documents wounds on sacral stage 4 pressure sore measuring 6.5 centimeters (CM) length x7.5 CM width x1.8 CM depth: treatment orders document: daily clean with saline, apply metronidazole 0.75%, calcium alginate and secure with foam dressing.R3's wound notes by V19, Nurse Practitioner (NP) dated 8/5/25, 8/12/25, and 8/19/25 documents: sacral stage 4 pressure sore wound measuring 7CMx 7.5x2. Treatment order documents: cleanse with wound cleaner, Dakin's gauze cover with abdominal pads secure with bordered gauze daily.R3's treatment administration record for August documents: sacrum leave allograft/contact layer on at least 3 days cleanse with normal saline, adaptic calcium alginate metrocream and cover with dry or foam dressing every day with start date of 6/5/25. Treatments not documented on 8/1, 8/3-8/8, 8/11-8/14, 8/18, 8/20-8/21.R3 wound notes by V20 (Wound MD) dated 7/31/25 documents head occipital stage 4 pressure sore measuring 12.5CMx 11.5 CMx0. 8CM. Treatment orders document daily: clean with dakins, apply metronidazole cream 0.75% on calcium alginate secure with 4x4 gauze and abdominal pads.R3's wound notes by V19 dated 8/5/25, 8/12/25, and 8/19/25 documents: occipital wound stage 4 pressure sore measuring 12.5CM length x 11.5 CM width x0. 8CM. treatment orders cleanse with wound cleaner, dressing applied hydro-feral blue foam and cover with abdominal pads and secure with gauze dressing daily.R3's treatment administration record for August documents: back of the head: cleanse with vashe. apply adaptic and vashe soaked gauze and cover with foam dressing. Wrap with kerlix daily with start date of 6/5/25. Treatments not documented on 8/1, 8/3-8/8, 8/11-8/14, 8/18, 8/20-8/21.R3 wound notes by V20 dated 7/31/25 documents left posterior knee stage 3 pressure sore measuring 1.7CMx 1.5x0.1 treatment orders document clean with normal saline, leave allograft/contact layer hydroferra blue and cover with dry dressing every other day.R3's wound notes by V19 dated 8/5/25, 8/12/25, and 8/19/25 documents: wound left knee stage 4 pressure sore measuring 1.7CMx1. 5x0.2. No treatment/dressing orders documented.R3's treatment administration record for August documents: left posterior knee clean with normal saline, apply adaptic calcium alginate cover with foam dressing/or bordered gauze daily with start date of 6/5/25. Treatments not documented on 8/1, 8/3-8/8, 8/11-8/14, 8/18, 8/20-8/21.R3 wound notes by V20 dated 7/31/25 documents right ischium stage 3 pressure sore measuring 7CMx6x1.6 daily half strength dakins apply gentamycin calcium alginate and cover with foam island.R3's wound notes by V19 dated 8/5/25, 8/12/25, and 8/19/25 documents: right ischial stage 4 pressure sore ischial stage 7CMx6x1.6cm. Wound treatment: cleanse with wound cleaner, dakins gauze packing.R3's treatment administration record for August does not document any treatments for right ischial area.R3 wound notes by V20 dated 7/31/25 documents right posterior thigh proximal measuring 5CMx 1 x0.1 with treatment daily normal saline cover with xeroform; right posterior thigh distal measuring 0.6CMx0.8x0.1 with treatment to clean with normal saline cover with xeroform.R3's wound notes by V19 dated 8/5/25, 8/12/25, and 8/19/25 documents: right thigh posterior stage 4 pressure sore measuring 5CMx1x0.2. Treatment documents: calcium alginate packing daily, clean with wound cleanser.R3's treatment administration record for August documents: right inner thigh monitor and off load daily. Treatments not documented on 8/1, 8/3-8/8, 8/11-8/14, 8/18, 8/20-8/21. There are no other treatments documented for right thigh area.R3's treatment administration record for August documents: left forehead, cleanse with normal saline and apply xeroform place dressing daily every Monday, Wednesday, and Friday. Start date 3/12/25. Treatments not documented on 8/1, 8/4,8/6, 8/8, 8/11,8/13, 8/18, 8/20.There are no assessments or measurements for left forehead wound in R3's medical record.R3's hospital record dated 8/23/25 documents:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145424	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Richton Park Rehab & Nsg Ctr	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 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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145424	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Richton Park Rehab & Nsg Ctr	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 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 observation, interview and record review, the facility failed to supervise R9 who was identified as high risk for elopement and moderate risk for wandering during a smoking break. This failure resulted in R9 climbing on top of a gazebo, jumping a fence, leaving the facility unauthorized without a pass, sleeping in an abandoned home with no utilities and on a train station platform for six days in cold inclement weather for one of one reviewed for supervision. Findings Include:R9 was admitted on [DATE] with the diagnosis of acute respiratory failure, pneumonia, asthma, hypertension, anemia and sleep apnea. R9 brief interview for mental status score documents 14/15 which indicates cognitively intact.R9's wander risk assessment dated [DATE] documents a score of ten (10) which indicate a moderate risk for wandering. R9's wander risk assessment dated [DATE] documents a score of fifteen (15). Score eleven and above indicate high risk to wander.R9's elopement risk review dated 10/10/25 documents high risk for elopement. Resident tried to escape through exit door 10 minutes after arriving at the facility.R9's care plan did not document any plan of care or interventions for elopement.On 12/4/25 at 3:25pm, R9 who was assessed to be alert and oriented to person, place and time said, during the 1:00pm smoke break, V12 (Activity Aide) gave him his cigarettes, and he went out on the patio to smoke. R9 said, V12 was in the building inside in the doorway and no staff was on the patio during his smoking break. R9 said, he got on top of the gazebo and hopped the fence on 11/27/25 Thanksgiving Day. R9 said, he fell and hurt his back when he jumped over the fence. R9 said, he lived near the facility in the past and his house was within walking distance of the facility. R9 said, he went to his house which was abandon with no working utilities and he slept inside his previous home until it became too dark and cold. R9 said, when he left his house, he slept outside at the train station because it had heated areas. R9 said, he wore three or four shirts, two pair of pants, two jackets and a vest. R9 said, he went back to the facility on Saturday 11/29/25 because he did not have anywhere else to go. R9 said, he was cold, dirty and smelled, but he was told by the facility receptionist (name unknown) that he could not come back until the head nurse returned to work. R9 said, he jumped the fence because he was told he could not have a pass unless someone signed him out of the building. R9 said, he did not have anyone to sign him out, it was an emergency, and he needed to see his family. R9 said, he was told he could not have a pass due to not being in the facility long enough.On 12/04/25 at 4:00pm, V12 (Activity Aide) said, she was the only activity aide monitoring R9'a smoking break. V12 said, she passed out cigarettes, open the patio door and light the cigarettes for the residents. V12 said, it was about ten to fifteen residents outside smoking. V12 said, if the weather is cold, she will stand in the doorway inside the facility. V12 said, she was not on the patio monitoring the residents smoking. V12 said, it was cold and she was inside the building in the doorway. V12 said, she was informed R9 jumped over the gate by R10. V12 said, she would have not known R9 was gone if R10 did not inform her. V12 said, nothing new had been implement since R9 jumped the fence. On 12/5/25 at 1:36pm, R10 who was assessed to be alert and oriented to person, place and time, said R9 stood on crate, jump on the gazebo railing and pulled himself up over the fence. R10 said, he finished his cigarette and then told V12, R9 jumped over the fence. R10 said, residents were standing inside of the gazebo smoking. R9 was at the back of the gazebo behind all the residents. R10 said, V12 was in the entrance way at the patio door. On 12/3/25 at 3:51PM, V13 (Nurse) said, R9 jumped over the fence. V13 said, a code was not called. V13 said, five residents coming off the elevator reported R9 left. V13 said, she could not recall the five resident's names. V13 said, she was the first nurse who was notified R9 left. R9 was chipper the day before he left. V13 said, R9 asked, if he could go out on pass the day he left. V13 said, R9 did not have an independent pass privilege. V13 said, R9 had not been admitted long enough to have an independent pass. V13 said, R9 reported he lived around the corner from the facility a few weeks before he left.On 12/4/25 at 5:18pm, V1 (Administrator) said, R9 jump the fence. V1 said, R9 did not elope. V1 said, R9 leaving was an unauthorized departure. V1 said, R9 was street savvy and responsible for himself. V1 said, the facility did not call R9's family. V1 said, the police were contacted. V1 said, R9's girlfriend was called. V1 said, R9's girlfriend number was not on R9's face sheet. V1 said, she guesses someone found R9's girlfriend's number but no one located a previous address for R9. V1 said, R9 summary episode has R9's previous address listed. V1 said, the police were familiar with R9 and was not concerned about his departure. V1 said, R9 came back because he didn't have anywhere else to go. V1 said, a resident can get a pass after being in the facility for twenty-one days.On 12/04/25 at 3:25pm, V15 (R9's family) said, she was not informed R9 left the