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	02/18/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that staff follow its medication administration policy by failing to sign the medication administration record, failed to ensure that staff properly reassess and document effectiveness of pain medication, and failed to properly account for the receipt and disposition of a psychotropic medication. This failure affected one (R3) of four residents reviewed for nursing care.Findings include:R3 is a [AGE] year-old male admitted to the facility on [DATE] post open reduction and internal fixation (ORIF 1/16/2026). Face sheet documented the following past medical history: Fracture of unspecified parts of lumbosacral spine and pelvis, subsequent encounter for fracture with routine healing, person injured in unspecified motor vehicle accident, anemia, anxiety disorder, other psychoactive substance abuse, uncomplicated, etc.On 2/1/2026 11:00AM, R3 was observed in his room, awake and alert, said that facility is not controlling his pain and not getting his pain medication orders straight, they told him he does not have an order for oxycodone, but it is clearly listed in his discharge summary.Physician order summary dated 1/27/2026 documented the following active orders:Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for Pain.Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 3 tablets by mouth every 6 hours as needed for Pain.On 2/17/2026 at 12:51PM, reviewed Medication Administration Record (MAR) for R3 and noted the following: MAR for January showed that Oxycodone or Tylenol was not signed out as given from admission [DATE]) to the end of the month. Per pharmacy manifest, oxycodone 10mg 30 tablets were delivered to the facility on 1/31/2026. Surveyor requested the narcotic receipt and disposition form for January and V2 said that she could not find it. For the month of February, Oxycodone was signed as given about 5 times, Tylenol has not been signed out at all. Pharmacy manifest for the month of February showed that oxycodone 10mg 24 tablets were delivered on 2/11/2026 and 28 tablets were delivered on 2/17/2026.Surveyor presented this observation to V2, Director of Nursing (DON) who said that R3 was getting oxycodone, the nurses are just not signing out the MAR, but they are signing out the narcotic sheet, she is going to provide education that R3 is supposed to be offered his Tylenol and if he refuses, it should be documented. V2 added that according to facility medication administration policy, the MAR was supposed to be signed by the person giving the medication.There are no documentations in resident's record that showed he refused any medication, the effectiveness of administered medications or any non-pharmacological interventions for pain management attempted, or any assessment of R3's surgical site every shift by floor nurses.On 2/17/2026 at 9:45AM V11 (RN) said that R3 had surgery but it is healed, they did an x-ray and determined that he does not have any new fractures. Surveyor asked V11 if she is aware that R3 still had staples on his surgical site and asked her if she had an idea when the staples will be removed. V11 said, I don't know, wound care takes care of that. Surveyor asked V11 if she has ever assessed resident's surgical site or aware of the swelling to his right hip. V11 said, I don't know all that, wound care takes care (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of that.Medication administration general guidelines (undated) stated in part- medications are administered as prescribed in accordance with good nursing principles and practices and only persons legally authorized to do so. Procedure #9. The MAR is initialized by the person administering medication in the space provided under the date, and on the line for that specific medication does administration. MAR is verified with a full signature in the space provided in the MAR or on a master signature sheet.10. When as needed (PRN) medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral), and if applicable, the injection or applicable site.b. Complaints or symptoms for which medication was given.c. Results achieved from giving the dose and the time results were noted.d. Signature or initial of person recording administration and signature or initials or person recording effects if different from person administering.Job description for registered nurse (RN) and Licensed practical Nurse (LPN) (undated) states in part, the RN/LPN direct nursing care to the residents and supervises the day-to-day nursing activities performed by nursing assistants. The person holding this position is delegated the administrative authority, with current federal and state regulations and established company policies and procedures that the highest degree of quality care is maintained at all times.B Role responsibility- Charting and Documentation5. Charts nurses' notes in an informative and descriptive manner that reflects the care provided to the residents as well as resident's response to care.12. Signs and dates all entries made in resident's medical record.C. Role responsibility- Drug administration.1.Prepares and administers medications as ordered by the physician.6. Ensures narcotic records are accurate for your shift.7. Notifies the nurse supervisor of all narcotic discrepancies noted on your shift.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a resident with services to avoid emotional distress and anguish by failing to assist a post-op patient with follow-up appointment, failed to ensure that resident was receiving therapy as ordered and failed to ensure that staff assist the resident with activities of daily living (ADL). These failures affected one (R3) of four residents reviewed for quality of care. As a result, R3 developed increased swelling, increased pain and blood clot to his right hip and stated that he feels hopeless since being admitted because he thinks nobody cares about his pain and healing process.Findings include:R3 is a [AGE] year-old male admitted to the facility on [DATE] post open reduction and internal fixation (ORIF 1/16/2026), past medical history includes fracture of unspecified parts of lumbosacral spine and pelvis, subsequent encounter for fracture with routine healing, person injured in unspecified motor vehicle accident, anemia, anxiety disorder, other psychoactive substance abuse, uncomplicated, etc.On 2/13/2026 11:00AM, R3 was observed in bed, awake and alert, and said he came to the facility 2 weeks ago post-surgery to his right and left hip. R3 said he missed his follow up appointment two weeks ago (2/3/2026) and last Wednesday (2/11/2026), facility did not give him any explanation, they said they did not know where he was supposed to go for the appointment scheduled 2/3/2026. R3 said he feels very upset and hopeless because no one at the facility cares, he came here for therapy but has not been receiving any therapy since admission. R3 said that he has not received any shower or bed bath, he tried to get himself up from bed to wheelchair because staff does not answer the call light. R3 said he has pooped on himself twice and sat on his urine and poop for hours because no one came to assist him.Physician order summary dated 1/27/2026 documented the following: Follow up appointment February 3, 2026 post op patient visit 10:15 am hospital outpatient center 2160 s first avenue Maywood Illinois 60153-3328 708 216 3834. Hospital discharge summary also has the same appointment boldly written on the first page. R3 also has the following orders: Clarification order, PT eval Tx 3x/wk. 4wks for therapeutic exercise, therapeutic activities, neuromuscular re-education, gait training, etc., for 30 days, start date 1/29/2026. Clarification order PT OT ST eval Tx one time only for 30 days, start date 1/29/2026.On 2/13/2026 at 11:45AM, observed dressing change for R3 with V5 (LPN/Wound Care) and noted resident's surgical site on his right hip to be swollen with staples intact, R3 said that the site is tender to touch and more painful than before. V5 said that he changed the dressing on R3's surgical site yesterday, the right hip was a little swollen but not as much as it is today, V5 is not sure if R3 is receiving therapy yet. R3 rated his pain as 10 on a scale of 1 to 10. V5 said he will notify the doctor and later said that the doctor ordered an X-ray and doppler for R3.On 2/13/2026 at 2:09PM, V2, Director of Nursing (DON) said that she did not know about R3's follow -up appointment scheduled for 2/3/2026, the admitting nurse is supposed to look at the order and pass the information to the scheduler. Surveyor informed V2 that the follow up appointment was in resident's physician order and was clearly written on the first page of the hospital discharge summary and she said that she is not sure why the appointment was not scheduled, she will investigate it. V2 later stated that she could not find out anything, resident's appointment was missed due to miscommunication. For the appointment that R3 missed on 2/11/2026, V2 said that the ambulance the facility arranged for R3 did not have a stretcher and could not transport R3. V2 said that she called and rescheduled the appointment for Monday February 16, 2026On 2/17/2026 at 10:36AM, V2 said that R3 missed his appointment again yesterday (2/16/2026) because the ambulance did not show up. V2 did not document anything about resident's missed appointments or notify the physician, stated that she told the floor nurse to write a progress note. V2 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	is not sure what date resident's staples are supposed to come out; the wound care nurse was supposed to call the doctor and get an order for that. Nurses are supposed to assess residents' surgical sites and document every shift. There are no documented assessments of resident's surgical sites in medical records by the nurses.On 2/13/2026 at 2:45PM, V6, Therapy Director said that he is familiar with R3, therapy saw resident for two weeks only and could not continue because resident had a non-weight bearing order from orthopedics. V6 said that they could only do upper body training for R3 and were waiting for his follow up appointment and an update on his weight bearing status.On 2/17/2026 at 10:32AM, V6 said that R3 is still not in therapy yet, he will start as soon as the ortho doctor gives an order for weight bearing status. V6 said that therapy for post operative patients should start as soon as they are admitted but R3 has a non-weight bearing order from the hospital, V6 thought that R3 will go for his follow up appointment and get an updated weight bearing order.On 2/18/2026 at 8:03AM, V13, Wound Doctor said that he just saw R3, the swelling to resident's surgical site could be due to edema or subcutaneous hematoma, they did an arterial and venous doppler that showed possible blood clot, he is ordering a venous ultrasound that may show what is causing the swelling. If the swelling is edema, it may resolve on its own but if it is a hematoma, it may need to be evacuated at the hospital. Regarding the staples to resident's surgical site, V12 said that they can be taken out anytime, but they are still there because R3 have not been to his post op appointment with orthopedics, but the site looks stable with no signs of infection. V13 is not sure why R3 has not been to his post-op appointment, that could be discussed with facility management.Radiology report dated 2/16/2026 for right lower venous doppler extremity- (hip and femur), indication localized swelling, mass and lump, pain and localized edema. Impression: Right popliteal vein is not compressible with possible echogenic material, likely due to deep vein thrombosis. Recommend clinical and lab correlationsMinimum Data Set (MDS) assessment dated [DATE], section C documented that R3 is cognitively intact, section GG (functional status) indicated that R3 requires substantial /maximal assistance for most Activities of Daily Living (ADL) needs, and dependent for toileting hygiene and transfers.ADL care plan initiated 2/6/2026 stated that in part: R3 has self-care deficit and require assistance with ADLs to maintain highest possible level of functioning. Interventions include substantial/maximal assist for bed mobility, partial/ moderate assist with bathing, dependent for transfers, etc.On 2/13/2026 at 11:30AM, surveyor observed a full urinal on R3's bedside table with his snacks and other personal items. Surveyor presented this observation to V4, Certified Nursing Assistant (CNA) who said that she is not assigned to the resident, the urinal is not supposed to be sitting on resident's bedside table because it is a hazard. V4 said that the urine should have been emptied by staff to avoid it spilling all over resident. V4 emptied resident's urinal.On 2/17/2026 at 11:38AM, during dressing change for R3 with V5, surveyor observed a urinal that was almost full of urine on resident's half rail, presented this observation to V5 who shook his head and dumped the urine in the bathroom.On 2/17/2026 at 9:50AM, V12, CNA said that she is not assigned to R3 today but have taken care of him in the past. She cannot recall giving resident a bed bath or assisting him with showers.Physician visits for medical specialties outside facility policy (undated) stated in part: Purpose - To coordinate visits with physicians that do not work within the facility for residents that require specialized services that are not provided within the facility.Procedure 1. Licensed nurse receives orders from the attending physician for the specialized medical services required. 2 The licensed nurse fills out an appointment communication form which is forwarded to medical records. 3. Medical records personnel makes the first available appointment for the resident with medical specialist. 5. The medical records personnel make transportation and escort arrangements as necessary.Guidelines for activities of (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	daily living policy (undated) state in part: Residents are given routine daily care and HS care by a certified nurse assistant (C.N.A) or a nurse to promote hygiene, provide comfort and provide a homelike environment. ADL care is provided throughout the day, evening and night as care planned and/or as needed.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to manage post-op pain for one resident (R3) by failing to administer pain medications (Oxycodone and Tylenol) as ordered, failed to monitor and document effectiveness of pain relief, and failed to use non-pharmacological interventions as part of the pain control regimen as care planned. This failure affected one (R3) of four residents reviewed for pain management. These failures contributed to R3 suffering psychological harm and feeling a sense of hopeless because no one cared about his pain or healing and pain rated 10 on a scale of 1-10.Findings include: On 2/1/2026 11:00AM, R3 was observed in his room, awake and alert, said that facility is not controlling his pain and not getting his pain medication orders straight, they told him he does not have an order for oxycodone, but was clearly listed in his discharge summary that was provided to the facility. Resident rated his pain as 10 on a scale of 1 to 10.Face sheet documented the following past medical history: Fracture of unspecified parts of lumbosacral spine and pelvis, subsequent encounter for fracture with routine healing, person injured in unspecified motor vehicle accident, anemia, anxiety disorder, other psychoactive substance abuse, uncomplicated, etc.Physician order summary dated 1/27/2026 documented the following active orders:Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for Pain.Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 3 tablet by mouth every 6 hours as needed for Pain.On 2/3/2026 at 11:15AM, V3, Licensed Practical Nurse (LPN) was passing medication on the third floor, stated that she was assigned to R3, he wanted pain medication and V3 told him that his pain medication was not scheduled. Surveyor asked V3 what time R3 was medicated for pain last, and she said, I don't know, he is asking for oxycodone, and it is ordered for every 4 hours, he does not even have the medication in the narcotic box right now.On 2/13/2026 at 2:09PM, V2, Director of Nursing (DON) said that R3 has an order for oxycodone, his medication is in stock, the nurse could not find it earlier but was able to find it now and it is in stock.On 2/13/2026 at 11:45AM, observed dressing change for R3 with V5 (LPN/Wound Care) and noted swelling to resident's right hip surgical site which he said was tender to touch and more painful than before, R3 again rated his pain as 10 on a scale of 1-10.On 2/17/2026 at 9:30AM, R3 said that the facility ran out of pain medication again, he did not receive any pain medication for the past 2 days.On 2/17/2026 at 9:45AM, surveyor asked V11 (RN) if R3 had any OxyContin in the narcotic box. V11 said, I was asked if R3 has any oxycontin in the narcotic box and I said, I already told him that that he has the medication, what is he complaining about now? Resident gets oxycontin every 4 hours and he asks for it on the clock, because it is a narcotic it must be reordered, resident runs out sometimes, he only gets 28 tablets at one time. V11 was asked if she has ever given R3 Tylenol for breakthrough pain and she said, he will not take Tylenol, he only wants oxycodone.Care plan initiated 2/10/2026 states that R3 is at increased risk for alteration in pain/discomfort. Goal: R3 will express relief/decreased discomfort 20-30 minutes after analgesic use. Interventions: Administer analgesic medication as ordered by the plan of care, Offer PRN analgesic medication prior to ADL activities/Rehabilitation, wound care etc. as indicated for pain management, observe resident for effectiveness of pain relief, Notify MD for any new resident complaints of pain and/or S/S of pain to obtain new order for medication regimen or break-through pain management.On 2/17/2026 at 12:51PM, reviewed Medication Administration Record (MAR) for R3 and noted the following: MAR for January showed that Oxycontin or Tylenol was not signed out as given from time of admission [DATE]) to the end of the month. Per pharmacy manifest, oxycodone 10mg 30 tablets were delivered to the facility on 1/31/2026. Surveyor requested the narcotic receipt and disposition form for January and V2 said that she (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	could not find it. For the month of February, Oxycontin was signed as given about 5 times, Tylenol has not been signed out at all. Pharmacy manifest for the month of February showed that oxycodone 10mg 24 tablets were delivered on 2/11/2026 and 28 tablets were delivered on 2/17/2026.Surveyor presented this observation to V2 who said that R3 was getting oxycodone, the nurses are just not signing out the MAR, but they are signing out the narcotic sheet, she is going to provide education. R3 is supposed to be offered his Tylenol and if he refuses, it should be documented. V2 added that according to facility medication administration policy, the MAR was supposed to be signed by the person giving the medication.Medication administration general guidelines (undated) stated in part- medications are administered as prescribed in accordance with good nursing principles and practices and only persons legally authorized to do so. Procedure #9. The MAR is initialized by the person administering medication in the space provided under the date, and on the line for that specific medication does administration. MAR are verified with a full signature in the space provided in the MAR or on a master signature sheet.10. When as needed (PRN) medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral), and if applicable, the injection or applicable site.b. Complaints or symptoms for which medication was given.c. Results achieved from giving the dose and the time results were noted.d. Signature or initial of person recording administration and signature or initials or person recording effects if different from person administering.Guidelines for pain management (undated) state in part: It is the intent of the facility to promote resident independence, comfort and to preserve resident dignity in an ongoing effort to promote the highest level of quality for their lives. One aspect of this commitment is to maintain an effective pain management plan to and therefore enhance their overall comfort and wellbeing.Pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does.