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 02/24/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interviews and records review, the facility failed to follow its guideline on Discharge/Transfers for one of one resident (R5) reviewed for transfers in a sample of 11 residents.On 2/10/26 R5 was sent out for an appointment. V27 (RN) stated that R5 arrived at the appointment location with no face sheet, physician order, or medication administration sheet. During an interview on 2/18/26 at 10:40am, V2 (Director of Nursing) stated that staff are aware of resident's appointments the day prior to the appointment and should have the paperwork ready on the day of the appointment. V2 stated that the facility's protocol is for a face sheet and a physician order sheet to be given to the transporter when a resident is picked up. During an interview on 2/17/26 at 4:30pm, V20 (RN, R5's night nurse) stated that she was not aware that R5 had an appointment. V20 stated that she did not send R5 with paperwork to his appointment because she could not get access to the computer room to retrieve the face sheet and physician order sheet that she had printed.Facility policy titled Guidelines for discharge and transfer.Purpose: A resident will be discharged or transferred by order of the attending physician in accordance with the specific state of federal standards and practice guidelines. All discharge plans will be care planned. Procedure. 4. Types of discharge for reference.A. Higher level of care (Emergency or planned Hospital Transfer). 1) Complete transfer form in (Electronic Health Record) EHR-EHR Discharge/Transfer Forma) Send face sheetb) Send advance directivesc) Send MAR/TARd) Other pertinent information or required information as per State regulation.Guidelines for activities of daily living. (ADL) (Routine Care) Policy: Residents are given routine daily care and HS by a Certified Nursing Assistant (CNA) or Registered Nurse (RN) to promote hygiene, provide comfort and provide a home-like environment. ADL care is provided throughout the day, evening and night as care planned and or as needed. ADL K is coordinated between the residents and the caregivers with emphasis on resident preference as much as possible.

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: 145424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2026
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	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to follow its guideline policy for activities of daily living for one of one resident (R5) reviewed for activities of daily living in a sample of 11 residents.On 2/10/26 R5 was sent out for an appointment. V27 (RN) stated that R5 arrived at the appointment location unclean, unkempt and has not been changed for some time. During an interview on 2/18/26 at 10:40am, V2 (Director of Nursing) stated that she was informed by R5's family that R5 was sent for his appointment on 2/10/26 unclean. V2 stated that R5's night nurse informed her that she did not have time to get R5 ready for his appointment. V2 stated that staff are aware of appointments the day prior to the appointment and should have the resident ready on the day of the appointment. V2 stated that R5 has a stage three pressure ulcer on his right heal which is being treated by the wound doctor. V2 stated that the facility's protocol is for a face sheet and a physician order sheet to be given to the transporter when a resident is picked up.During an interview on 2/17/26 at 4:30pm, V20 (RN, R5's night nurse) stated that she was not aware that R5 had an appointment. V20 stated that she instructed a nursing assistant to clean R5 while she prepares R5's paperwork. V20 stated that she is not sure if R5 was cleaned.Facility policy titled: Guidelines for activities of daily living. (ADL) (Routine Care)Policy:Residents are given routine daily care by a Certified Nursing Assistant (CNA) or Registered Nurse (RN) to promote hygiene, provide comfort and provide a home-like environment. ADL care is provided throughout the day, evening and night as care planned and or as needed. ADL K is coordinated between the residents and the caregivers with emphasis on resident preference as much as possible.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services 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 follow its colostomy care policy, resulting in a colostomy leak that led to potential skin irritation and infection. This applies to 2 of 2 residents (R3 and R8) reviewed for colostomy care in a sample of 11.The findings include:R3 is a [AGE] year-old male admitted on [DATE] with cognition intact as per 11/25/25 and admitted with an admitting diagnosis including colostomy and urinary tract infection (UTI).On 2/17/26 at 2:00 PM, R3 was observed in his bed with his colostomy bag leaking.On 2/17/26 at 2:10 PM, V5 (Certified Nursing Assistant / CNA) stated that she didn't get a chance to check on R3 upon his arrival back from the hospital. The colostomy shouldn't leak, and the nurses are supposed to take care of the colostomy.On 2/18/25 at 10:25 AM, R3 was observed in his bed with a new colostomy bag and was leaking through the base dressing. On 2/18/26 at 10:25 AM, V25 (CNA) stated that she will notify the nurse and that the colostomy shouldn't leak.R8 is a [AGE] year-old male admitted on [DATE] with severe cognitive impairment as per the MDS dated [DATE].On 2/17/26 at 2:30 PM, R8 was observed on his bed with a colostomy leaking with a moderate amount of stool on his stomach.On 2/17/26 at 2:30 PM, V7 (Licensed Practical Nurse / LPN) stated, The colostomy was changed today. I don't know who changed it, and it shouldn't leak.On 2/18/26 at 12:05 PM, V3 (Nurse Consultant) stated, Nurses are supposed to change colostomy, and it shouldn't leak as it can cause skin irritation and infection.The facility presented an undated colostomy care policy document (version #2). The purpose of colostomy care is to prevent infection and skin irritation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its indwelling catheter and colostomy care policy, as evidenced by colostomy leakage and failure to maintain the urinary catheter bag and tubing below bladder level. This applies to 2 of 2 residents (R3 and R8) who were reviewed for infection control practices in a sample of 11.The findings include:1.R3 is a [AGE] year-old male admitted on [DATE] with cognition intact as per 11/25/25 and admitted with an admitting diagnosis including colostomy and urinary tract infection (UTI).On 2/17/26 at 2:00 PM, R3 was observed in his isolation room (due to COVID-positive) with a contact isolation sign posted on the door. R3 was observed on his bed at an elevated position with a urinary catheter and bag in bed.On 2/17/26 at 2:00 PM, R3 stated, I just came back an hour ago from the hospital. My urine and stomach were hot, and my infection was too bad, and I came back from the hospital on Sunday (2/15), then I went back again on Monday (2/16) as I was too sick.On 2/17/26 at 2:05 PM, R3's colostomy bag was observed leaking, and the colostomy bag insertion site was resealed with additional tape to prevent leaking. The suprapubic catheter site was observed with a dirty, soaked, loose dressing below the colostomy bag.On 2/17/26 at 2:10 PM, V5 (Certified Nursing Assistant / CNA) stated that she didn't get a chance to check on R3 upon his arrival back from the hospital. The colostomy shouldn't leak, and the nurses are supposed to take care of the colostomy.On 2/24/26 at 12:40 PM, V2 (Director of Nursing / DON) stated, When a resident is readmitted from the hospital, the nurse should check on that resident right away and make sure all tubing and drains are in a safe position to work safely. R3 is COVID positive, and hence staff should have initiated droplet isolation.On 2/18/25 at 10:25 AM, R3 was observed in his bed with colostomy leaks through the base dressing. R3 stated that the colostomy bag was leaking onto my catheter site and might have caused a UTI for me.On 2/18/26 at 10:25 AM, V25 (CNA) stated that she will notify the nurse and that the colostomy shouldn't leak.A review of R3's Physician Order Sheet (POS) indicates that R3 is getting intravenous antibiotic therapy with Meropenem 500 milligrams every six hours for UTI.2.R8 is a [AGE] year-old male admitted on [DATE] with severe cognitive impairment as per the MDS dated [DATE].On 2/17/26 at 2:30 PM, R8 was observed on his bed with a colostomy leaking with a moderate amount of stool on his stomach.On 2/17/26 at 2:30 PM, V7 (Licensed Practical Nurse / LPN) stated, The colostomy was changed today. I don't know who changed it, and it shouldn't leak.On 2/18/26 at 12:05 PM, V3 (Nurse Consultant) stated, Nurses are supposed to change colostomy, and it shouldn't leak as it can cause skin irritation and infection. The urinary catheter and bag should be maintained below bladder level to prevent urine backflow to prevent potential infection.The facility presented an undated colostomy care policy document (version #2). The purpose of colostomy care is to prevent infection and skin irritation.A review of the facility presented Guidelines for Indwelling Foley Catheter care/Suprapubic Catheter Care document:Always keep the urinary drainage bag below the level of the bladder. While modern systems have safeguards to prevent the backflow of urine, this is still good practice.