STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39781 Based on observation, interview, and record review the facility failed to protect and promote resident rights of a vulnerable resident. This deficiency affects one (R59) of three residents in the sample of 17 reviewed for Resident's right. Findings include: On 3/5/25 at 8:19AM, Observed R59 in recliner chair wearing sweater with multiple large food stained in front of her sweater. She is alert but confused and totally dependent with ADLs (Activity of daily Living). V11 CNA (Certified Nurse Assistant) said that her sweater is clean, but they cannot remove the food stained. V11 added that the facility does her laundry. On 3/4/25 at 11:14AM, Informed V6 Social Service Director of above observation. V6 said that they have to treat resident with dignity. R59 should be wearing clean and neat clothing. The CNA should change R59's sweater and dress her with clean and neat clothing. Facility's policy on Resident's right indicated: At a minimum, federal law specifies that nursing home must protect and promote the following rights of each resident. You have the right to: * Be treated with Respect: You have the right to be treated with dignity and respect.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50469 Based on observation, interview, and record review the facility failed to ensure resident call light is within reach. This deficiency affects 1 (R47) of 3 residents in the sample of 17 reviewed for Accommodation of needs. Findings include: On 03/04/25 at 07:57 AM, R47 observed in bed, call light behind bed on floor. R47 said he cannot find the call light, he looked for it but could not find it. On 03/04/25 at 08:08 AM, V14 (Certified Nurse Aide) said that call light should be within reach, said she is not sure why call light is not next to him. On 03/06/25 at 10:09 AM, V2 (Director of Nursing) said that all residents should have call light within reach to ask for assistance, call lights should not be behind bed or on floors. R47 is admitted on [DATE] with diagnosis in part but not limited to HTN, chronic respiratory failure with hypoxia, Pneumonia, PVD, Left lower extremity osteomyelitis status post left above knee amputation and right below knee amputation, Cerebrovascular disease. A focus care plan I require partial/moderate assist with one staff. Intervention dated 6/6/23 Keep call light in reach. Facility's policy on Guidelines for Call light revisions 3/4/24. Policy: It is the policy of the facility to have a system in place to allow the staff to respond promptly to resident's call for assistance and to ensure that the call system is in proper working order. The call system will be available in the resident's room as well as in the resident's bathroom. Procedure: 9.) Always be sure that the resident has a functioning call light that is the easiest type for them to use. Always place the call light in an accessible location to where the resident is located in their room. Tell the resident where it is. Be sure they know how to use it. Call light cords are not to be wrapped around bed rails or bed frames which could cause them to be pulled out of the wall within movement of the bed or rail.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 40001 Based on record review and interview the facility failed to submit for a PASRR level 11 (Preadmission screening resident review-PASRR) for 2 of 3 residents (R22 and R39) reviewed for PASRR level 11 in a sample of 17. Findings include: On 3/5/2025 at 11:30am R22 said I don't think I'm in a program for mental health. On 3/5/2025 at 12:30pm V 6(Social Services Director) said I was not aware that R22 had an order for psychological services or a change in her medication I will submit for a PASRR level 11 and make sure that if a program is prompted that it is the correct program. On 3/6/2025 at 10:00am V1 (Administrator) said the social services department is responsible for submitting for a PASRR level 11 the information would come from the psychotropic nurse, I'll make sure the social service department is aware of that information to assure that the resident's are in the correct program. An order summary report indicated that R22 had a gradual dose reduction for Risperdal 1 mg on 1/29/2025 order on 5/17/2024 for resident to receive psychological services as needed, psychiatrist consult as needed, physiatrist consult as needed, may do random drug testing as needed. On 3/5/2025 R39 has an order summary report dated 3/6/2025 that indicated on 2/18/2025 R39 may receive psychological services. On 3/5/2025 at 1:00pm V6 said I was not aware that R22 had an order for psychological services, I submitted for a PASRR LEVEL 11 screening on today and I will ensure she's in the correct program. On 3/6/2025 at 10:30am V1 said I will ensure that all resident's that need a PASRR level 11 screening receive it. Facility policy: Guidelines for PASRR PROCESS PASRR is a federally mandated process that requires all states to pre-screen all residents regardless of their payer source or age who are seeking admission to a Medicaid funded nursing facility. PASRR has 3 goals. 3. To ensure people, (resident's), receive the required services for mental illness and or IDD.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to provide nail care and foot care to dependent resident. This deficiency affected all four (R36, R45, R54, and R59) residents in the sample of 17 reviewed for Activity of Daily Living (ADL) Program. Findings include: On 3/4/25 at 8:19AM, Observed R59 in recliner chair with long dirty fingernails with V11 CNA (Certified Nursing Assistant). On 3/4/25 at 8:20AM, Observed R36 lying in bed with V11 CNA with dirty long fingernails. On 3/4/25 at 10:41AM, Observed R54 lying in LAL (Low air loss) mattress with V8 Restorative Nurse. He has tracheostomy connected to ventilator. He is totally dependent with ADLs care. Observed R54 has long dirty fingernails. Observed black matter underneath the fingernails. V8 said that CNAs (Certified Nurse Assistant) are responsible for providing nail care to resident during ADLs care. Observed R54's long thickened and discolored toenails. V8 said that CNAs should report to nurse when observed resident with long thickened toenails, so they can refer to podiatrist. Informed V8 that R36 and R59 were observed to have dirty and long fingernails. R54 is admitted on [DATE] with diagnosis listed in part but not limited to Encephalopathy, Respiratory failure, Chronic Obstructive Pulmonary disease, Cerebral infarction, Dependent of respirator/ventilator, Tracheostomy status, Gastrostomy status. Comprehensive care plan indicates that he has a self-care deficit, and he requires assistance with ADLs to maintain highest possible level of functioning. Intervention: Personal hygiene: require total assistance and 1 staff personal hygiene (Totally dependent on staff). On 3/4/25 at 11:19AM, Observed R45 with V5 Wound Care Coordinator and V18 CNA preparing to provide wound care. Observed bilateral hands with long and dirty fingernails. Observed black matters underneath the fingernails. Observed long thickened and discolored toenails. V5 said that CNAs (Certified Nurse Assistant) are responsible for providing nail care to resident during ADLs care. V5 said that CNAs should report to nurse when observed resident with long thickened toenails, so they can refer to podiatrist. R45 is readmitted on [DATE] with diagnosis listed in part but not limited to Senile degeneration of brain, Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Vascular dementia, Type 2 Diabetes Mellitus. Comprehensive care plan indicated he has a self-care deficit, and he requires assistance with ADLs to maintain highest possible level of functioning. Intervention: Personal hygiene: require total assistance and 1 staff personal hygiene (Totally dependent on staff). On 3/4/25 at 11:30AM, Informed above observation to V2 DON (Director of Nursing) and requested policy. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/25 at 10:06AM, Observed R59 in recliner in the dining room with V3 ADON. Observed R59's bilateral hands still with dirty long fingernails. Observed black matter underneath her fingernails. Informed V3 that R59 was observed with long dirty fingernails since yesterday morning. V3 said that she will ask CNA provide nail care to R59. R59 is readmitted on [DATE] with diagnosis listed in part but not limited to Sequelae of Cerebral infarction, Senile degeneration of brain, Metabolic encephalopathy, Vascular dementia, Section GG Functional abilities GG0130 Self-care coded (1) dependent for Personal hygiene. Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity. Comprehensive care plan indicated that she has a self-care deficit and require total assistance with ADLs to maintain highest possible level of functioning. She demonstrated cognitive impairment. R36 is readmitted on [DATE] with diagnosis listed in part but not limited to Dementia, Parkinson, Muscle wasting and atrophy, Pressure ulcer of sacral stage 3. Comprehensive care plan indicated she has self-care deficit and require assistant to maintain the highest level of functioning. Intervention: Personal hygiene: usually require substantial/maximal assistance. On 3/5/25 at 11:14AM, V6 Social Service Director said that he schedules resident for podiatrist visit/consult if the nursing staff notified him. V6 said that he was not aware that R54 needed to be seen by podiatrist until yesterday. V6 said that R54 is already scheduled for podiatrist for this month. Facility's policy on Activities of Daily Living (ADL) (Routine Care) indicates: Policy: Residents are given routine daily care and HS (Bedtime care by a CNA (Certified Nurse Assistant) 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. ADL care is coordinated between the resident and the care givers with emphasis on resident preference as much as possible. ADL care of the resident includes: *Assisting the resident in personal care such as bathing, showering, dressing, eating, hair care, oral care, nail care, appropriate skin care (as indicated and as per care plan) as well as encouraging participation in physical, social, and recreational activities. Facility's policy on Guidelines for Nail care dated 3/27/23 indicates: Purpose: it is policy of the facility to provide personal hygiene needs and to promote health, safety, and the prevention of infection. This includes clean, smooth nails at a safe length acceptable to the residents. Facility's policy on Guidelines for Podiatrist Services dated 5/24/23 indicates: Policy: The goal is for the residents to maintain as much mobility as possible and to experience good foot health. Procedure: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Residents will have foot care completed as part of the bathing/showering and nail care policies on a routine basis as part of their ADL care. Any observations on the feet from the above list observed by any caregivers will be immediately reported to the charge nurse for further assessment and appropriate reporting to the attending physician and follow up. 7. The Social Services Director will assist in coordinating/scheduling the podiatrist visit.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to ensure ongoing assessment is done to identify new skin impairment, document and notify physician for appropriate treatment in a timely manner to a resident who is at high risk for skin impairment. The facility failed to formulate wound/pressure care plan and implement LAL (Low air loss) mattress manufacturer's recommendation in prevention and management of wound care. These failures resulted R54 to develop DTI (Deep tissue injury) on right heel. This deficiency affects all five residents (R28, R36, R45, R54 and R59) in the sample of 17 reviewed for Wound/Pressure ulcer prevention and treatment management. Findings include: On 3/4/25 at 8:07AM, Observed R28 sleeping in a LAL (low air loss) mattress bed with V10 Family member at bedside. V10 said that R28 is totally dependent with ADLs (Activity of Daily Living). V10 said that last week Friday (2/28/25), R28 re-opened her sacral pressure ulcer. V10 said she noticed it when she assisted the CNA (Certified Nurse Assistant) in performing incontinence care and they applied wound dressing. V10 said she notified the ADON (Assistant Director of Nursing), and V5 Wound Care Coordinator (WCC) came to see R28, both were aware of R28's re-opened sacral pressure ulcer. Observed R28 has fitted sheet covered the LAL mattress and a cloth pad over the mattress. R28 wears disposable brief. On 3/4/25 at 8:11AM, Observed R59 lying in LAL mattress bed with flat sheet folded in half and cloth pad over the mattress. R59 wears disposable adult brief. V11 CNA said that R59 should only have flat sheet over the LAL mattress. The night shift CNA is the one who did apply the multi layers of linen over the mattress. On 3/4/25 at 8:20AM, Observed R36 lying in LAL mattress bed with V11 CNA. Observed R36 has flat sheet and cloth pad over the mattress. R36 wears disposable brief. On 3/4/25 at 8:25AM, Observed R54 lying in LAL mattress bed with V5 WCC. Observed flat sheet and cloth pad over the mattress. R54 wears disposable brief. V5 said that R54 should only have flat sheet over the mattress. No multi-layer of linens as manufacturer's recommendation. On 3/4/25 at 8:30AM, Observed R45 lying in LAL mattress bed with V5 WCC. Observed flat sheet and cloth pad over the mattress. R45 wears disposable brief. V5 said that R45 should only have flat sheet over the mattress. No multi-layer of linens. Informed V5 of above observation made to R28, R36 and R59 with multi layers of linen over the LAL mattress. V5 said that residents on LAL mattress should only be on flat sheet so it will not affect the purpose of LAL mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/4/25 at 10:04AM, V5 WCC said that she is responsible for wound assessment and treatment for resident with pressure ulcers and other skin conditions. She said, resident who is admitted with skin impairment or open wound should have skin assessment with measurement done by the floor nurse or herself. The physician will be notified to obtain appropriate treatment and care plan will be updated. V5 presented list of residents with skin impairment/pressure ulcers in the facility. The list did not indicate R28 and R54. On 3/4/25 at 10:21AM, Informed V5 WCC of V10 Family member reported that R28 has re-opened her sacral pressure ulcer last Friday (2/28/25). V5 said that she is not aware, and this is her first time hearing this report. V10 Family member denied statement of V5 and reminded her that she came to see R28 on 2/28/25 after she reported to ADON about R28's re-opened sacral wound. V10 added that V5 did not see the wound because the floor nurse applied wound dressing, but she reported to her. V5 said, she probably forgot about it. V5 then started preparing to perform wound assessment and treatment. She wears only gloves, she opened R28's disposable brief then she repositioned R28 to her left side and removed her brief. The brief is clean, but the wound dressing is contaminated with black fecal matters. Observed R28 has fitted sheet and cloth pad over the LAL mattress. R28 has sign posted at her door indicated Enhanced Barrier Precaution. V5 cleansed open sacral wound with normal saline solution (NSS). V5 said, R28 has stage 2 pressure ulcer. Observed clean pinkish tissue and whitish color (maceration) at peri wound. V5 measured sacral wound and obtained 0.5cm x 0.4cm x0.1cm. V5 said that she will call R28's physician to obtain treatment order. On 3/4/25 at 10:41AM, Observed R54 lying in LAL mattress bed. He has tracheostomy tube connected to ventilator. He has gastrostomy tube connected to feeding bag. He is awake and non-verbal. V5 assisted with V8 Restorative Nurse to remove R54's bilateral heel protectors. Observed R54 dressing on the following: Left dorsal foot, left lateral ankle, right inner/medial lower leg, and right heel. Wound dressing dated 3/2/25. V5 said that she was not aware of this wound dressing because there is no order in his chart. V5 removed all wound dressing and cleansed with NSS then did measurement. Left dorsal foot has 1.5cm x1.5cm dry necrotic scab. Left lateral ankle pressure ulcer measures 2.5cm x 1.3cm with 50% pinkish tissue and 50% necrotic dry scab. Right inner/medial lower leg measures 1.5cm x 0.5cm. Observed bleeding granulating, reddish tissue, full thickness. Right heel DTI measures 4.5cm x 6cm, 35% necrotic tissue, 10% red tissue exposure, 65% maroon discoloration. V5 painted betadine to all wounds and covered with bordered dressing. V5 said that she calls the physician to obtain treatment orders to all new identified skin impairments for R54. On 3/4/25 at 11:19AM, Observed R45 lying in LAL mattress bed. He is alert, responsive but with episodes of confusion. V5 WCC assisted with V18 CNA preparing R45 for wound care. V18 open his disposable brief. He as morbid obese abdomen. Surveyor requested to check for underneath his abdominal folds. R45 screams for pain as V18 lifted his abdomen. Observed MASD (Moisture associated skin disorder) underneath the abdominal folds with fluids. Both V5 and V18 said that the fluid from his urine (due to anatomical position of his genital/penis). R45 continues to scream for pain as V18 and V5 cleansed the abdominal folds. Surveyor asked V5 if R45 has scheduled pain medication. Both said that R45 always complains of pain even just touching him. V5 said that she is not aware of this MASD, and this is new for her. V5 applied barrier cream. Then V18 positioned R45 to his left side. V5 said that R45 has Stage 4 sacral pressure ulcer. She applied collagen sheet and covered with foam dressing. V5 said that she will call R45's physician about MASD on abdominal folds. On 3/6/25 at 10:03AM, Reviewed R28, R54, R45, R36 and R59 medical records with V5 WCC. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R28 is readmitted on [DATE] with diagnosis listed in part but not limited to Type 2 Diabetes Mellitus, Dementia, Contractures on right and left ankle, left and right hand, Gastrostomy, Chronic Kidney disease. Active physician order sheet indicates: Weekly skin checks for wound prevention. Moisture barrier ointment apply to buttocks and peri area topically every shift for skin protection secondary to incontinence. No wound treatment addressing to re-opened sacral wound on 2/28/25. Comprehensive care plan indicated she has as alteration in skin integrity and is at risk for additional and or worsening of skin integrity issues related to impaired cognition related to dementia, impaired mobility, and other medically related diagnosis. Intervention: Skin will be checked during routine care daily and during weekly bath/shower schedules. Any skin integrity issues /concerns will be conveyed to the charge nurse for further evaluation and or treatment changes/new interventions and the physician will be called as needed. Pressure reducing/relieving mattress. Informed V5 that Physician was not notified of re-opened sacral wound, did not obtain appropriate treatment intervention, care plan was not implemented and updated not until the surveyor addressed the concerns during survey. Informed V5 that wound assessment done with surveyor on 3/4/25 was dated 3/3/25, it was signed on 3/5/25. R54 is admitted on [DATE] with diagnosis listed in part but not limited to Encephalopathy, Respiratory failure, Emphysema, Chronic obstructive pulmonary disease, paralytic syndrome following cerebral infarction bilateral, Tracheostomy status, Gastrostomy status, Muscle wasting and atrophy. Braden scale/skin assessment upon admission (2/11/25) and most recent (3/2/25) indicated that He is at very high risk for developing pressure sore. No admission wound assessment and measurement was done. Admission notes dated 2/11/25 indicated open areas multiple, scrotum under red, right outer leg open, back open area, multiple scabs back, back upper open area, back middle open area, toenails thick, top right great toe bruise, left hand callus, right ball foot scab, heel right red area, right inner lower leg red open area, left leg multiple scars, right lower leg scars. Active physician order indicated No treatment orders addressing the identified skin impairment upon admission. V5 did not complete skin assessment after admission. Wound care physician initial wound assessment dated [DATE] indicated: 1) Diaper dermatitis on perineal and buttocks. Treatment recommended- moisture barrier or zinc oxide, 2) Venous stasis on left big toe. Treatment - betadine paint. 3) Open blister on left mid back. Treatment- zinc oxide or Vit A& D. Treatment ordered were written in physician order sheet and not carried out not until the surveyor addressed the concerns. V5 write the treatment recommended by wound care physician on 2/17/25 not until 3/4/25 during survey. R54 physician order sheet and Treatment administration record indicated that treatment orders recommended by wound care physician was only documented on 3/4/25. Informed V5 WCC that they failed to implement its policy and procedure on prevention and treatment management of pressure and non-pressure wounds. They failed to ensure ongoing assessment is done to identify new skin impairment, document and notify physician for appropriate treatment in a timely manner to resident who is at high risk for skin impairment. R54 developed DTI on right heel, open wound on lateral ankle and open wound on right medial lower leg. It was not identified, documented, and did not obtain appropriate treatment from the physician not until the surveyor identified it during survey. No comprehensive care plan was developed upon admission to address the skin impairment and prevention of developing pressure ulcer. V5 said that the previous MDS/Care plan coordinator was the one responsible for developing wound/pressure ulcer care plan. V5 submitted all new identified wounds with assessment and measurement done with surveyor on 3/4/25, signed and dated on 3/6/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R45 is readmitted on [DATE] with diagnosis listed in part but not limited to Type 2 Diabetes Mellitus, Senile degeneration of brain, Chronic obstructive pulmonary disease, Hemiplegia, and hemiparesis following cerebral infarction affecting left non dominant side, Vascular dementia, Muscle wasting and atrophy. Most recent Braden scale/skin assessment (1/24/25) indicated that he is at high risk for skin impairment. Active physician order indicated Sacrum: cleanse with NSS, apply collagen sheet or puracol, zinc oxide around then cover with foam silicone dressing daily and as needed. Weekly skin assessment. Moisture barrier ointment apply to buttocks and peri area topically every shift for skin protectant secondary to incontinence. No treatment order for MASD abdominal folds that was identified on 3/4/25 with surveyor. Comprehensive care plan indicated that he has an alteration in skin integrity and is at risk for additional and or worsening of skin integrity issues. Interventions: Skin will be checked during routine care on daily basis and during weekly bath /shower. Any skin integrity issues/concerns will be conveyed to the charge nurse for further evaluation and or treatment changes new interventions and the physician will be called as needed. Pressure reducing/relieving mattress (low air loss mattress). Informed V5 WCC that they failed to implement its policy and procedure on prevention and treatment management of pressure and non-pressure wounds and implement care plan interventions. They failed to ensure ongoing assessment is done to identify new skin impairment, document and notify physician for appropriate treatment in a timely manner to resident who is at high risk for skin impairment. R36 is readmitted on [DATE] with diagnosis listed in part but not limited to Parkinson, Dementia, Muscle wasting and atrophy, Stage 3 sacral region pressure ulcer. Active physician order sheet indicates: Low air loss mattress. Treatment sacrum: Apply protective dressing as needed for skin protective dressing. Comprehensive care plan indicated she is at risk for alteration in skin integrity. Most recent Braden scale assessment dated [DATE] indicated at risk for developing pressure ulcer sore. Informed V5 WCC of multilayers of linens over the mattress on 3/4/25. R59 is readmitted on [DATE] with diagnosis listed in part but not limited to Sequelae of cerebral infarction, Senile degeneration of brain, Metabolic encephalopathy, Subarachnoid hemorrhage, Vascular dementia. Comprehensive care plan indicated she is at risk for alteration in skin integrity related to impaired cognition, incontinence of bladder and bowel and impaired mobility. Intervention: Pressure relieving/reducing mattress. Informed V5 WCC of multilayers of linens over the mattress on 3/4/25. On 3/6/25 at 12:51PM, Informed V24 Medical Director of above concerns identified that the facility failed to ensure ongoing assessment is done to identify new skin impairment, document and notify physician for appropriate treatment in a timely manner to residents who are at high risk for skin impairment. The facility failed to develop wound/pressure care plan and implement LAL (Low air loss) mattress manufacturer's recommendation in prevention and management of wound care. V24 said that they should follow and implement the facility's policy and procedures in prevention, treatment and management of wound/pressure ulcers. Facility's policy on Wound Assessment indicates: It is the policy of this facility to complete a systematic, ongoing assessment of all wounds that will provide a consistent means of wound evaluation to determine the response to treatment modalities and to facilitate continuity of care and communication among staff and healthcare providers on an ongoing basis. (continued on next page)

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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

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Procedure: I. The presence of wounds, injuries and or other skin abnormalities will be identified upon admission/readmission or identification of a new wound, pressure injury, or other skin abnormality. A. The staff will complete a complete skin and wound assessment upon admission/readmission, identify any wounds, pressure injuries or other skin abnormality and document it in the medical records. B. The wound team will complete a skin and wound assessment and document the presence of any wound assessment in the medical record. C. Any wound, pressure injury or other skin abnormality identified during the resident's stay will be documented in the same manner as when identified upon admission/re/admission. II. Wounds are measured weekly by the wound team or designee A. The status of the wound is documented in the medical record B. Wound status is also monitored with each dressing change C. Any changes in the wound are documented at the time identified and the physician and family are notified. Facility's policy and procedures on Treatment/services to prevent /heal pressure and non-pressure wounds revised 11/2/23 indicated: Policy: It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental and psychosocial needs. Procedure: 1. The facility will ensure that based on the comprehensive assessment of a resident: 1a. A resident receives care, consistent with professional standards of practice to prevent pressure and non-wounds and does not develop pressure or non-pressure wounds unless the individual's clinical condition demonstrates that they were unavoidable as documented by the wound care specialist. 1b. A resident with pressure ulcers or non-pressure wounds received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new wounds from developing. 2. Upon admission, the resident will receive a head-to-toe skin check to identify any skin issues. 3. Interventions will be implemented by the nurse in the resident's plan of care to prevent pressure sore development when the resident has no areas of concern. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	4. When the resident is admitted with a pressure or non-pressure wounds the admitting nurse or wound care nurse will document the size, location, odor, drainage, and current treatment ordered. 5. Interventions will be implemented in the resident's plan of care to prevent deterioration and promote healing of the pressure and non-pressure wound. 6. The admitting nurse will notify the attending physician as well as the resident and or resident's representative of the condition of the wounds that were observed on admission. 7. The pressure and non-pressure wounds will be evaluated weekly by the wound care nurse and or the wound care specialist. 8. If the wound care specialist changes any treatment or indicates other interventions the wound care nurse will put these orders in the resident's electronic medical record. 9. The nurse will notify the resident and or the resident's representative of any changes related to the improvement, deterioration and or treatment changes on an ongoing basis. Facility's policy Guidelines for Low Air Loss Mattress use dated 7/18/23 indicated: Purpose: To provide the features of a support system for the resident that provides a flow of air in managing the heat and humidity (microclimate) of the skin. Procedure: 8). A single non fitted sheet may need to be utilized on the mattress for assistance in positioning and repositioning the resident. Fitted sheets are not recommended. Quilted reusable pads and incontinent briefs tend to block the airflow and trap moisture against the skin. Disposable, air permeable incontinence pads designed for low air loss mattresses should be used instead.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49871 Based on observation, interview, and record review the facility failed to follow side rail physician order and care plan. The facility also failed to implement safety transfer to a dependent resident who is high risk for fall affecting 2 of 3 (R37, R59) residents reviewed for Accident Hazards in a total sample of 17. Findings include: On 3/4/2025 at 9:15 AM, R37 in bed with three side rails up. R37 said she doesn't know why those rails were up and that she did not request it. On 3/4/2025 at 9:17 AM, V3 (Assistant Director of Nursing) stated R37 should have two side rails up but V3 said not sure of the policy. On 3/4/2025 at 11:11 AM, V8 (Restorative Nurse) stated there should only be two side rails up while in bed. V8 said one of the side rails was zipped tight today. On 3/5/2025 at 8:50 AM, V2 (Director of Nursing) stated side rail assessment is completed by Restorative at least quarterly for mobility, there should be a physician order, and no more than two side rails up. Review of R37 Medical Records read: Admission Record dated 1/13/2025 with Diagnosis Information of Unilateral Primary Osteoarthritis, Left Hip, Cerebral Infarction, Unspecified. Order Summary Report dated 2/11/2025, R37 May use Bilateral 1/4 Side Rails when in bed for repositioning every shift. Care Plan Report: Focus: R37 could benefit from use of Non-Restrictive Side Rail(s); Bilateral, 1/4 Side Rail (s), date initiated 10/14/2024. Side Rail Review dated 1/23/2025: Recommendations, two side rails. Policy and Procedure for Use of Side Rail/Grab Bars as an Enabler for Bed Mobility, 2/28/19 It is the intent of the facility to provide the licensed medical staff with a process for the evaluation, documentation needs and necessary interventions relating to Side Rails/Enabler bars evaluation and utilization. Side Rail/Grab bar will be used to enable and promote the highest practicable level of independence in terms of turning/repositioning (Bed Mobility) and psychosocial well-being in relation to client's medical condition. A side rail/Grab bar will not be utilized for purposes of facility/family's convenience. Procedure: 2. Side Rail/Grab bar assessment will be completed by staff member and deemed if the use of Side Rail/Grab bar is appropriate to maintain the highest level of functioning of the client. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Staff to obtain physician order for the use of Side Rail/Enabler Bar as enabler to assist client in turning and repositioning. 6. Staff to evaluate client every quarter and PRN for the need of Side Rail/Enabler bar. 9. The facility will develop a plan of care to address the use of Side Rail/Enabler Bar. 39781 On 3/4/25 at 8:19AM, Observed V11 CNA (Certified Nurse Assistant) transferring R59 by herself, lifting from bed to recliner chair. R59 is awake but confused. V11 said that she will bring her to dining room for breakfast. V11 said that R59 needs total care with her ADLs (Activity of Daily Living), and she is on hospice care. R59 is readmitted on [DATE] with diagnosis listed in part but not limited to Sequelae of Cerebral infarction, Senile degeneration of brain, Metabolic encephalopathy, Vascular dementia, Unsteadiness on feet, Dizziness and Giddiness, Abnormality of gait and mobility. Re-admission fall assessment (4/10/24) and most recent fall assessment (1/25/25) indicated that R59 is at high risk for fall. R59 's history of fall incidents on the following dates: 1/25/25, 8/6/24, 6/11/24, 4/6/24 and 3/1/24. MDS/Resident assessment dated [DATE] Section GG Functional abilities GG0170 mobility coded (1) dependent for chair/bed to chair transfer. Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity. Comprehensive care plan indicated that she is at risk for falls as evidenced by the following risk factors and potential contributing diagnosis: Cognitive impairment, decreased strength and endurance, general weakness, use of psychotropic medications. She demonstrated cognitive impairment. She required total assistance with 2 staff members to operate mechanical lift to complete the transfer. Intervention: The facility will follow the mechanical lift policy and procedure to ensure and correct procedure with use of equipment. She will be transferred with 2 persons transfer when using a mechanical lift. On 3/5/25 at 12:12PM, Review R59's medical records with V8 Restorative Nursing. Informed V8 of above observation made to R59 transferring by V11 CNA from bed to recliner chair by herself. V8 said that R59 should be transferred from bed to recliner chair by mechanical lift with 2 persons assist for safety as indicated in her care plan. Facility's policy on Guidelines for Mechanical lift transfer/Usage indicates: Intent: The nursing department will complete an ADL assessment to determine the transfer needs of all residents upon admission, re-admission, quarterly and as indicated due to a change in the resident's condition. These assessments are completed, in part, to promote resident safety and to main the highest practicable level of ADL function for all residents. Many residents who require 2 persons transfer will need to be transferred using a mechanical lift to include a floor based, full body sling lift- overhead full body sling lift as well as a sit to stand lift. This type of transfer must be the safest method based on the resident's assessed ability to safely assist in their own transfer. The 2 staff members are required when a mechanical lift is used. There must be a complete/detailed physician order for mechanical lift transfers. The use of mechanical lift must be documented in the resident's plan of care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy on Resident handling policy limited lift indicates: The resident handling policy exits to ensure a safe working environment for resident handlers. The policy is to be reviewed and signed by all staff that perform or may perform resident handling. This policy will be reviewed annually with changes made accordingly. *Initial screening will be performed on all residents to assess transfer and ambulation status. *Resident transfers will be designated into one of the following categories: M=Mechanical lift transfer- Full lift/Hoyer (2 Caregivers). Facility's policy on Safety Program revised August 2022 indicated: It is the policy of the organization to promote a safe environment for resident. Visitors and employees through the safety program.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 40001 Based on observation, interview and record review the facility failed to ensure the gastrotomy tube placement was checked prior to administering medication for 1 of 1 resident (R49) reviewed for enteral feeding in a sample of 17. Findings include: On 3/4/2025 at 8:30am V12 (Licensed Practical Nurse-LPN) was observed by this writer administering medication and did not check for placement before administering, V12 was asked how the facility checks for feeding tube placement. On 3/4/2025 at 8:33am V12 said we check for gastric residual, I guess I forgot. On 3/4/2025 at 1:00pm V1 (Director of Nursing-DON) said the nurses should check for feeding tube placement by pulling up gastric residual and by listening to gastric sounds via stethoscope. A review of R49 Admission Record indicates that R49 has a diagnosis of gastrostomy status, dysphagia. A care plan dated 3/12/2024 that indicates R49 has an intervention to assess/check for gastric residual volume per facility policy and procedeure. Facility Policy: The facility was unable to present a feeding tube placement policy.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45316 Based on observation, interview and record review the facility failed to follow their policy on posting direct care daily staffing numbers. This failure has the potential to affect 69 residents receiving care in the facility. Findings include: On 03/06/2025 at 11:30am this surveyor along with V23 (Scheduler) did not observe the daily staffing posting anywhere upon entrance into the facility. V23 was made aware that the daily staffing posting was not observed by this surveyor since 3/4/2025. V23 said that the daily staffing posting should have been posted at a designated area by the front desk. On 03/06/2025 at 11:45 AM, V2 (Director of Nursing-DON) said that the daily staffing posting should have been posted. BIPA Staffing Posting Requirement Policy: It is the policy of the facility, in cooperation with Medicare/Medicaid Services, (CMS), to comply with the requirement of daily posting of nursing staff in the facility. Procedure: 1) SNFs and NFs must post daily, at the beginning of each shift, the facility specific shift schedule for the 24-hour period, the number and category of nursing staff employed or contracted by the facility for each 24 hour period, as well as the total number of hours worked by licensed nursing staff who are directly responsible for resident care.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50469 Based on observation, interview, and record review the facility failed to ensure resident refrigerators have recorded temperature log affecting 2 of 3 (R28, R29) residents reviewed for resident refrigerator in a sample of 17. Findings include: On 03/04/25 at 08:03 AM, Observed R29 personal refrigerator with 8 soda cans, 2 juice bottles, 1 container of [NAME] slaw salad not dated, the temperature log last updated on 2/3/25. No March 2025 log available. On 03/04/25 at 08:03 AM, R29 said that the staff usually comes in everyday to check the refrigerator temp log, they have not been in here yet. On 03/04/25 at 12:04 PM, R29 said that staff has not come in yet, not sure why. On 03/05/25 at 12:04 PM, V5 said that housekeeping logs the temperature every day to monitor refrigerator for temperatures and food. On 03/06/25 at 10:52 AM, V1 (Administrator) said that housekeeping monitors resident personal refrigerators daily and records logs, V1 said they are unable to find personal refrigerator policy. Facility's Policy on Food Brought into Facility by Friends/Family/Others (Outside Sources) for Residents Policy revised 11/28/2016. Policy: Special circumstance, such as persistent weight loss or specific preferences or special events may require/indicated that food be brought into the facility from an outside source (friends/family/others). Due to the potential for foodborne illness or interference with nutritional treatment, family members and or friends/others who bring in food/drink in from the outside will be educated on safe food handling practices as well as the importance of diet order compliance. Foods or beverages brought in from the outside will be monitored by nursing staff for spoilage, contamination and safety. Procedure: 4. Facility staff will monitor resident rooms, resident personal refrigerators, unit pantries as well as facility refrigerators and freezers for food and beverage disposal needs for safety. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. All refrigerators in use in the facility have an internal thermometer to monitor temperature. All refrigerators have their internal temps recorded daily. Any refrigerators are found to have an internal temperature that is outside of the accepted safe parameters of temperatures will be immediately addressed by maintenance and will be taken out of service if the internal temperature cannot be corrected within a reasonable time frame to maintain food safety. Any affected food/beverages will be discarded. 39781 On 3/4/25 at 8:07AM, Observed R28 sleeping in bed with V10 Family member at bedside. V10 said that she brings food and beverages from home for R28. Observed R28's personal refrigerator filled with bottled water, juices, and supplemental drinks. Observed daily monitoring log sheet is for cooler not for resident's personal refrigerator. The log indicated date starting at March 3 (Monday) 40F, no monitoring was done on March 1 (Saturday) and 2 (Sunday). On 3/4/25 at 10:30AM, Informed V3 ADON (Assistant Director of Nursing) of above observation, showed monitoring log and requested for copy. On 3/4/25 at 10:35AM, V17 Housekeeping and Laundry Supervisor said that she checked /monitored and recorded resident's personal refrigerator thermometer reading daily. She said that she does R28's daily refrigerator temp monitoring. Surveyor showed R28's refrigerator's March monthly temperature monitoring initiated on March 3, no March 1 and 2 was done. She said that she was off on those days. V17 said she does not know the acceptable temperature ranges for the refrigerator and was referred to Maintenance department. Informed V17 that the monitoring log that she used is for cooler not for resident's refrigerator monitoring form. Requested for policy. On 3/5/25 at 9:58AM, Rounds made with V3 ADON to R28's room. Observed no refrigerator's daily temperature monitoring form. V3 read inside refrigerator temperature reading at 44F. V3 said she's not familiar with acceptable temperature ranges. On 3/5/25 at 11:01AM, Informed both V21 Maintenance Assistant and V22 Regional property manager of above observation and concern. The facility unable to provide policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to ensure appropriate infection control practices for residents on enhanced barrier precaution and during ADL (Activity of Daily Living) care. This deficiency affects all four (R28, R47, R49 and R59) reviewed for Infection Control Program. Findings include: R59 On 3/4/25 at 8:19 AM, After V11 CNA (Certified Nurse Assistant) transferred R59 from bed to recliner chair, she gathered all soiled linens with gloves on from the bed closer to her chest/upper body. The soiled linens touching her clothes and both arms. Then she placed the linen on top of the mattress. Informed V11 CNA of observation made. She said that she should gather the linen away from her and placed it in a plastic bag. On 3/4/25 at 9:58AM, Informed V2 DON (Director of Nursing) of above observation. V2 said that the CNA should gathered the soiled linen from the bed away from her body and placed it in a plastic bag. R28 On 3/4/25 at 10:11AM, Observed V16 CNA and V10 Family member performing incontinence care to R28. V16 wearing gloves and V10 wearing gloves and cloth mask. R28 has sign posted at her door indicated that she is on Enhanced Barrier Precaution (EBP). On 3/4/25 at 10:21AM, V5 WCC (Wound Care Coordinator) came into R28's room to perform wound assessment and treatment. She is only wearing gloves. After wound care, surveyor informed V5 of observation made that appropriate infection control practices are not being implemented during direct care to the resident such as incontinence and wound care. V5 said that she forgot to wear proper PPE when performing wound care to resident on EBP. She should be wearing gown and gloves during the procedure. V5 said that the CNA should also wear gloves and gown during incontinence care. V10 Family Member said, she saw the EBP posting, but staff did not tell her to wear gown and gloves when providing direct care to R28. On 3/4/25 at 10:39AM, Informed V3 ADON/Infection Preventionist of above observation. V3 said that staff should wear gown and gloves when providing direct care to R28 who is on EBP. R28's active physician order sheet indicated that she is on Enhanced Barrier Precautions (EBP): Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high contact resident care activities: Providing hygiene, Wound care .Comprehensive care plan indicated that she is on EBP for feeding tubes. Interventions: Follow EBP guidelines when providing care. ` Facility's policy on Guidelines for Enhanced Barrier Precautions (EBP), An extension of Personal Protective Equipment (PPE) reviewed/revised [DATE] indicates: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy: it is the policy of the facility to ensure that additional and appropriate PPE is utilized, when indicated, to prevent the spread of Multidrug-resistant organism also known as MDROs. EBPs are defined as the use of PPE (gowns and gloves) during high contact resident care activities that generate opportunities for transfer on MDROs in the form of blood or body fluids onto the hands and or clothing of the rendering caregiver. EBP is to be used when contact precautions do not otherwise apply and where there is a diagnosis of a MDROs or a colonized MDRO. Examples of High contact resident care activities at which time EBP is to be practiced are: d)Providing hygiene- ADLs e) Changing linen g)Device care or use to include: *Wound care (any related device) Procedure: 1) When engaging in any of the afore mentioned High contact resident care activities with a resident who has a known MDRO or a colonized MDRO or who would be at a high risk to contract a MDRO-use gloves and gowns (EBP) with the same technique/practice as in contact precaution use. This includes all required hand hygiene before and after donning/doffing glove and gowns. 40001 On 3/4/2025 at 8:30am V12 (Licensed Practical Nurse-LPN) was observed by this writer administering medication to R49 via a feeding tube with only gloves. On 3/4/2025 at 8:35am V12 said I should have on my gown, I forgot. On 3/4/2025 at 1:00pm V2 (Director of Nursing-DON) said I expect the staff who's doing direct patient care to have, full enhanced barrier protection not just gloves. A review of R49 Admission Record indicates that R49 has a diagnosis of gastrostomy status, dysphagia, a order summary report dated 3/4/2025 that indicates R49 has a medication order for Bactrim DS 800-160mg and Flagyl 500mg for infection for 14 days, a care plan updated on 3/4/2025 a focus of antibiotics and is at risk for adverse reactions, an intervention to follow universal precautions to prevent cross contamination and spread of infection, and a intervention to follow enhanced barrier precautions when providing care including feeding tube. 50469 On 03/04/25 at 07:23 AM, upon floor observation, R47 room observed with Enhanced Barrier Precautions sign posted next to room, but no isolation bin set up next to room or in the hallway. (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	03/07/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/25 at 12:48 PM V5 (Wound Care Coordinator) made aware of above findings and also observed no isolation bin set up outside of room or in the hallway and said that usually the isolation set bin is placed outside the room, V5 said she is unsure what happened to the isolation bin it is not outside the room. On 03/06/25 at 10:15 AM, V2 (Director of Nursing) said that the enhanced barrier precaution signage is posted outside of room and the isolation set up is usually laced under sign, each room is assigned an isolation bin set up. Staff should wear appropriate PPE as indicated. R47 is admitted on [DATE] with diagnosis in part but not limited to HTN, chronic respiratory failure with hypoxia, Pneumonia, PVD, Cerebrovascular disease, Osteomyelitis, Coronary artery disease, Neuropathy, Lymphedema, Osteoarthritis, spondylosis, sacral ulcers, anemia. A focus care plan I am on enhanced barrier precautions for Wounds or skin openings requiring a dressing. Intervention dated 10/09/24 Set up isolation per facility protocol. Follow the enhanced barrier precautions guidelines.