STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145648	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Nursing Home	2450 North Central Avenue Chicago, IL 60639

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to treat a resident's personal belongings with respect. This failure affects one (R1) resident out of four residents reviewed for resident rights. Findings include: On 09/19/2025 at 9:47AM, V3 (R1's Family Member) states she transferred R1 to another nursing home and her uncle went to pick R1's items up from the facility. V3 states her uncle noticed chocolate leaking on R1's clothes and all of R1's things were placed in one bag and on a filthy cart. On 09/23/2025 at 11:39AM, V2 (Director of Nursing/DON) states she was out of the facility and received a phone call from V6 (Licensed Practical Nurse/LPN) informing her that R1's male family member arrived to the facility to pick up R1's belongings. V2 states the facility was not aware that R1's family would be picking up R1's belongings. V2 states to her understanding, R1's clothes were placed in a clear plastic bag and given to R1's male family member. V2 states V6 (LPN) told her that she would let a Certified Nursing Assistant/CNA staff member pack up R1's belongings. V2 states the male family member refused to take R1's clothes and only took a picture of R1's belongings. V2 states she later found out that R1's male family member refused to take R1's belongings due to them being covered in chocolate. V2 states a week later, she received a phone call from V3 (R1's Family Member) stating that V3 wanted a refund for R1's belongings due to chocolate getting all over R1's clothes. V2 states she offered V3 to wash R1's belongings but V3 refused. V2 states V3 also asked to speak with V1 (Administrator) about the matter. V2 (DON) states she informed V3 (R1's Family Member) that V1 was in a meeting. V2 states she gave V1's contact information to V3 and V3 stated she would call V1 back. V2 states she informed V1 about the matter and later asked V1 (Administrator) if V3 had contacted her and V1 said V3 had not contacted her yet. V2 states when a resident goes out to the hospital, their belongings are packed up by the CNA staff and placed in storage. V2 states resident belongings should be packed properly and food items are not supposed to be packed with clothing items. On 09/23/2025 at 2:23PM, V6 (Licensed Practical Nurse/LPN) states R1's brother came to the facility to pick up R1's belongings but she was unaware of where R1's belongings were located. V6 states she then called V2 (DON) and sent V7 (CNA) to go and try to locate R1's belongings. V6 states she is not sure who packed R1's belongings but V7 came back with R1's bag already packed and brought it down on a rolling cart. V6 states R1's brother refused to take R1's belongings due to chocolate being spilled all over R1's clothes. V6 states she saw there was a bottle of chocolate syrup located inside of R1's clothing bag and had wasted all over R1's clothes. V6 states the facility offered to wash R1's clothes but R1's brother refused to take R1's belongings and then left the facility. An attempt to contact V7 (CNA) was made on 09/23/2025, no answer, left voice message, awaiting call back.On 09/23/2025 at 2:36PM, V1 (Administrator) states she was never made aware by anyone that V3 (R1's Family Member) wanted to speak to her about a refund regarding R1's clothing. V1 states V2 (DON) just informed her today that there was an incident involving R1 having chocolate wasted on her clothes. V1 states food items should not have been placed in a bag with R1's clothes and it was most likely an error. Facility policy dated 03/2025 titled Personal Property documents in part, 2. Resident's belongings are treated with respect by the facility staff, regardless of perceived value.