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	01/02/2026

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure an adequate supply of clean towels and linens. Also, that the towels and linens are in good condition and available for resident care. This failure has the potential to affect all 52 of the residents residing on the 2nd floor.Findings include:On 12/23/25 at 11:33 AM, R3 stated she had to buy her own face and hand towels because the facility does not have enough. R3 said, they are short on everything. R3 stated they do not give the CNAs (Certified Nursing Assistants) enough towels to do their job. R3 stated one time when they had to change her, they had to dry her off using a sheet because they did not have a clean towel. R3 stated, the CNAs are always telling her, I don't have this. I don't have that and they never have enough linen especially the towels. R3 stated they must search for supplies to give her the care she needs and that is sad. R3 stated their job is hard enough. R3 stated the sheets have holes in them, and the sheets and towels look dingy (dirty looking, spots on them that look like feces stains). R3 stated one time the only fitted sheets a CNA could find each had a large hole in them. So, what she had to do is put one of the fitted sheets on R3's bed with the hole toward the head of the bed and then the CNA put the 2nd fitted sheet over the 1st sheet but turned it so the hole on that sheet was at the foot of the bed. R3 stated this way the holes were technically covered but she was still laying on sheets with holes on them and that should not be. R3 stated she does not sleep on sheets with holes on them at home and she should not be doing that here, that is not right.On 12/24/25 at 10:19 AM, R12 stated the facility needs to have more towels and face/wash cloths because they do not have enough of them. R12 stated she uses the face/wash cloths to wash her face and a lot of the time they do not have any so R12 cannot wash her face when she wants to. R12 stated when she asks for a face/wash cloth the staff tell her that they do not have any to give her. R12 stated when this happens, she is not able to wash her face and if she was at home she would be able to wash her face when she wanted which is first thing in the morning as part of her regular routine.On 12/23/25 at 12:00 PM, did not observe available towels (bath or face/wash cloths) on the 2nd floor.On 12/23/25 at 1:05 PM, V15 (Laundry) stated there are a set amount of linen supplies he is supposed to deliver each morning to the units however the amount he can deliver is dependent on what he gets back from the units, what is in rotation. V15 stated for example, this morning he only delivered 16 towels (a combination of bath and face towels) to the 2nd floor because that is all he had on hand. V15 stated he knows that is not enough towels for the unit, but the staff will have to make do because that is all he had available to send. V15 stated the staff cuts the bath towels into smaller sized face/wash towels to use as rags to wipe the residents when changing them. V15 stated those cut up towels look like this and held up tattered and very frayed pieces of cut towels, that appeared thin, worn and had a rough texture to them. The cut towels were light gray in color, not white. V15 stated they are doing this because there are not enough face/wash cloths in circulation. V15 stated because there are not enough face/wash cloths the staff uses pillowcases or the flat sheets to clean the residents with. V15 stated he knows the staff is doing this because the pillowcases and flat sheets are coming down to laundry covered in feces, pus, and blood. V15 stated he uses bleach to try to remove the stains but some of the stains will not come out. Surveyor observed V15 randomly picked up three blankets folded in the cleaned area of the laundry room and each blanket had various sized circles of brown stains on them. V15 stated he cannot get those stains out even though they have technically been cleaned. V15 stated he should throw out items he cannot get the stains out of, but the linen/towel supply is too small, so he does not want to throw anything out without being able to replenish the items. V15 stated he cannot send no linen/towels to the unit, so he must send items even if they have stains on them. V15 stated there is a supply closet with new towels/linen but he does not have a key to it or know how to access the supply inside.On 12/23/25 at 1:40 PM, V16 (Licensed Practical Nurse) stated she is one of the nurses covering the 2nd floor unit today and there are 52 residents on unit. V16 stated the staff does not have enough towels to do what they need to do to take care of the residents and that she hears the CNAs complaining all the time that laundry does not deliver enough towels. V16 stated she sees the CNAs having to leave the floor to search for towels so they can clean up their residents. V16 stated the staff uses face/wash cloths to clean up the residents when providing incontinent care and the staff are so short face/wash cloths that they cut up the bath towels into smaller sections, so they have something to use to clean up the residents with. V16 stated she has seen the staff use pillowcases and sheets to clean the residents because they have run out of towels. V16 stated there should be at least two

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to prevent resident to resident physical assault for two (R10, and R11) out of four residents reviewed for abuse. This failure resulted to R10 sustaining a skin abrasion. Findings Include:R10's Minimum Data Set (MDS) dated [DATE], Brief Interview Score (14) indicates R10 is cognitively intact. R10's Electronic Health Record/EHR shows she was admitted to the facility on [DATE], and she is [AGE] years old.On 12/24/25 at 1:07 PM, R10 reported to surveyor that as she was coming out of the dining room after eating dinner, she cannot remember the date or time R11 hit her as he was walking into the dining room. R10 used her hand to indicate that R11 hit her with a closed fist on the left side of her face. She stated R11 hit her on purpose, and it hurt when he hit her. She also stated that she went to the nursing station because she was bleeding on the left side of her face. V30 (Licensed Practical Nurse/LPN) and V31 (Certified Nursing Assistant/CNA) wiped the blood from her face, so she refused to go to the hospital because it was a little scratch. R10 stated she has not seen R11 since the incident, she feels safe in the facility, and that staff has been applying ointment twice a day and she denies any pain at this time. Surveyor observed mall scar on the left lower side of R10's face, open to air and no signs or symptoms of infection.On 12/24/25 at 1:22 PM, V1 (Administrator) stated she was made aware of the abuse allegation between R10, and R11. V1 stated R10 and R11 were both walking down the hallway, he flung his hand and hit R10 in the face, she sustained an abrasion, but she does not know if R11 intentionally hit R10 or not. R11 was sent out for psychiatric evaluation, and he is still in the hospital.On 12/24/25 at 1:57 PM, V30 (Licensed Practical Nurse) stated on 12/15/25, R10 approached her and told V30 that R11 had hit her in the face. V30 stated she called V3 (Assistant Director of Nursing) to the unit and she came up to the unit right away, called the police, R10 and R11's physicians and their family members. V30 stated she could see blood on R10's face and the blood were coming from the left side of R10s' face. V30 stated R11 hitting R10 was not an accident. V30 stated R10 is a calm person and keeps to herself. She does not provoke anyone. R10 was upset but not crying. She kept asking are they sending him out? Are they going to send him out? V30 stated R11 was petitioned to go to the hospital for a psychiatric evaluation because R11 had hit R10. V30 stated when the ambulance arrived R10 declined going to emergency room, and she signed that she did not want to go to the hospital. V30 stated R10 said that she had given her first aid and it was only a scratch and therefore she did not need to go to the hospital for anything. V30 stated she has seen R10 since this event and that R10 has not verbalized having any fear and is not saying she does not feel safe at the facility. V30 stated there has been no change in R10's behavior or mood, a resident hitting another resident is an example of physical abuse, it is important to know the different kinds of abuse and monitor the residents for abuse because the residents should feel safe in the facility.On 12/24/25 at 2:22 PM. V3 (Assistant Director of Nursing) stated when she assessed R10, she could tell R10 was frightened because she was shaking, almost as if she was in shock about what just happened. V3 stated R10 is the nicest lady and is always calm, R11 was a new admit so the facility did not really know his behavior and up until that point he did not show any signs or symptoms of agitation, irritability, or aggression. V3 stated she could see blood on R10's face coming from a superficial skin tear on the left lower side of her face.On 12/24/25 at 2:45 PM, V31 (CNA) stated that R10 came to report that R11 struck her on the side of her face. She noticed a small cut with little bleeding on R10's cheek, she stayed with R11 to provide one-on-one monitoring until the Chicago police came. V1 is the abuse coordinator, and hitting another resident is a resident-to-resident physical abuse.On 12/30/25 at 11:33 AM, R11 received in the dining room, stated he pushed his index finger (showed the surveyor his index finger) on the left side of R10's face (pointed his finger on the lower left of his face), but he did not know why he pushed his finger on her face. He also stated that he saw little blood on R10's face, he felt bad, and he will be mad if someone pushed finger on his face. He has not seen R10 since the incident, no one has been abusive to him, and he feels safe in the facility.Nurses progress notes on 12/15/25 document in part: Resident (R11) was assessed following an incident in which he struck another resident (R10) in the face while passing her in the hallway.Police report dated 12/15/25 document in part: Battery Simple.R10's skin only evaluation dated 12/20/25 document in part, skin abrasion, left face.R11's Trauma, abuse, neglect screening assessment dated [DATE].Abuse Policy, undated, document in part: Residents have the right to be free from abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report resident to resident physical abuse to the State Agency for two (R10, R11) out of four residents reviewed for abuse.Findings Include:On 12/24/25 at 1:07 PM, R10 reported to a fellow surveyor that she was hit in the face by R11 as R11 was walking into the dining room. R10 used her hand to indicate that R11 hit her with a closed fist on the left side of her face. R10 stated she went to the nursing station to report it because she was bleeding on the left side of her face. R10's Minimum Data Set (MDS) dated [DATE] indicates R10 is cognitively intact. R10's skin evaluation dated 12/20/25 indicates skin abrasion left side of face close to the chin (1.5x1.0x0.1). On 12/24/25 at 1:57 PM, V30 (Licensed Practical Nurse) stated on 12/15/25, R10 told her that R11 had hit her in the face and V30 could see blood coming from the left side of R10's face. V30 stated she called V3 (Assistant Director of Nursing) to the unit and the police, R10 and R11's physicians and family members were notified. V30 stated R11 was petitioned to go to the hospital for a psychiatric evaluation because R11 had hit R10. R11's electronic health record (EHR) dated 12/15/25, 18:10 progress note entered by V3 (Assistant Director of Nursing) documented in part, the resident was assessed following an incident in which he struck another resident in the face while passing her in the hallway and the attending physician, resident's family and facility administrator were notified. On 12/30/25 at 11:33 AM, R11 reported to a fellow surveyor that he pushed his index finger (showed the surveyor his index finger) on the left side of R10's face (pointed his finger on the lower left of his face) and that he saw a little blood on R10's face.R11's MDS dated [DATE] indicates intact cognition. On 12/30/25 at 2:38 PM, V3 stated she was the one to call V1 (Administrator) at the time of the incident because V1 is the Abuse Coordinator. V3 stated she also called V2 (Director of Nursing) to report the incident to her as well. V30 stated she does not know who reported it to the State Agency. V30 stated that is not her job and she does get involved with reporting to the State Agency, only to notify V1. On 12/24/25 at 1:22 PM, V1 (Administrator) stated any abuse with an injury must be reported to the State Agency within 2 hours and then the facility has five business days to complete the investigation and send a final report to the State Agency. V1 stated she was notified over the phone on 12/15/25 about the incident between R10 and R11. V1 stated V2 was the one who submitted the reportable to the State Agency on 12/15/25 and the final was sent on 12/22/25. V1 stated when you submit a facility reported incident to the State Agency an email is not always generated to serve as proof of the time and date the facility submitted the report. V1 stated to get a confirmation back from the State Agency there is an extra step which needs to do done to receive one. Surveyor observed V1 looked through the facility reportable documentation dated 12/15/25 and stated, I don't see the State Agency confirmation letters attached which means the DON who submitted the report didn't know she was supposed to do that step. That is why there is no confirmation for the date/time submitted to the State Agency.On 12/30/25 at 9:05 AM, V2 (Director of Nursing) stated on the night of the incident between R10 and R11 V3 had called her and told her what happened and V3 reported that she had already notified V1. V2 stated she had already left the building and did not have access to a computer because she was at a concert. V2 stated she sometimes she completes the initial paperwork and V1 will ask her to submit the initial report to the State Agency but this time because V2 did not have access to a computer. V2 stated V1 told V3 that V1 would complete the initial paperwork and submit it to the State Agency. V2 stated if V1 wanted her to submit the report to the State Agency V1 would have texted her about it and V1 did not text her anything about it that night because V1 knew she was at a concert and did not have access to a computer. V2 stated abuse allegations need to get reported to the State Agency within two hours of the event and when V2 does submit to the State Agency she does it via email. V2 stated the State Agency does not send her a confirmation email so what she does is print out a copy of the email she sent to the State Agency which has the date/time sent and includes this email with the other paperwork for the abuse allegation/investigation as confirmation the State Agency was notified. V2 stated like she said she had no involvement in this case initially. V2 stated for the final report she did get involved in the interviewing part of the investigation but V1 did not ask her to send the initial or final to the State Agency.On 12/31/25 at 12:15 PM, V1 stated V2 keeps saying that V1 did the initial submission on 12/15/25 but V1 was under the impression that V2 was doing it. V1 said, most of the time it is me. I don't remember doing it. I thought the Director of Nursing was doing it. V1 stated it might have been a miscommunication problem. Surveyor with V1 looked through the other abuse reportables from the past three months and noted there is a confirmation

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record reviews, the facility failed to follow their policy to investigate and prevent further allegation of abuse. This failure affects one (R2) out of three residents reviewed for abuse. Findings Include: On 12/23/25 at 2:58 PM, via telephone, R2 stated that V21 (Certified Nursing Assistant/CNA) was verbally abusive to her because she said that R2 cannot clean her own a** and she will get to R2 when she is able. R2 cannot remember the date/time and there was no witness. R2 also stated that V22 (Restorative Aide) played mental games with her by showing up to provide restorative therapy and often came to her when she is doing something else.On 12/23/25 at 3:58 PM, Surveyor informed V1 (Administrator) that R2 has allegation of verbal abuse against V21, and mental abuse against V22, she stated she has no report against V21 and V22 by R2, but she will follow up. On 12/26/25 at 4:12 PM, V1 stated the facility protocol/policy on staff to resident abuse is that the employee would be immediately suspended and not be allowed to return until her investigation is complete however this is different because she concluded her investigation prior to those employees being scheduled again. This situation is different because R2 is no longer in the building, and she cannot afford not to have staff here especially over the holidays so even though she has five days to complete her investigation, she completed as soon as she could so that she would not have to suspend any employees. V1 also stated that she notified V21 and V22 on 12/23/25 that there was an allegation of abuse against them and completed her investigation on 12/24/25. She talked to V22 on 12/23/25 on the phone about the allegation and interviewed him then. She finished the interviews related to V22 on 12/24/25. V22 was not working on 12/24/25 or 12/25/25. She talked to V21 on 12/23/25 about the allegation, interviewed her and finished all the interviews she needed related to V21 on 12/23/25. She felt comfortable letting her come to work on 12/24/25. Because she was able to make the determination right away the staff was allowed to return to work and did not need to be suspended. On 12/31/25 at 12:32 PM, V1 stated that technically, she had already made the decision on 12/23/25 not to substantiate the allegation so the interviews she did on 12/24/25 were not going to have an impact on her decision. Because of this she does not have any problem bringing them back to work. She allowed both to work on 12/24/25 because she had finished her investigation on 12/23/25. On 12/24/25 at 11:15 AM, V22 (Restorative Aide) stated that he did not abuse R2 mentally; he did not play mental games with her by asking to provide her restorative program when she was in the middle of something. On 12/30/25 at 11:02 AM, surveyor observed V22 on the first floor, stated that 12/24/25 was the first time V1 spoke with him about mental abuse allegation by R2.On 12/24/25 at 12:04 PM, V21 (CNA) stated she is familiar with R2, she was not verbally abusive to her, she did not abuse her, and she did not tell R2 that she cannot wipe her own a**.On 12/31/25 at 11:01 AM, V2 (Director of Nursing/DON) stated that it is the policy of the facility to suspend immediately any staff accused of abuse pending the final investigation to protect other resident from potential abuse. If the alleged staff is on duty at the time of the report, the staff should punch out immediately, but if the alleged staff is out of the facility at the time of the report, the facility will notify the staff not to come to work while investigation is ongoing.Documents reviewed for this investigation are not limited to the following: Abuse Policy documents in part: Protect residents from any further harm during investigations.Abuse Investigation and Reporting documents in part: The administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. Abuse in-service attendance record dated 6/23/25, and 9/7/25. Reportable dated 12/23/25, and final faxed to the State Agency on 12/30/25.

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F 0684 Level of Harm - Minimal harm or potential for 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 interviews, and record reviews, the facility failed to administer medication as prescribed by the physician. This failure affects two (R2, R4) out of five residents reviewed for medication administration. Findings Include: R2's Electronic Health Record/EHR shows she was admitted to the facility on [DATE], she is [AGE] years old with a Brief Mental Status/BIMs score of 15. R2 has diagnoses not limited to Glaucoma, anxiety disorder, and major depressive disorder.R4's Electronic Health Record/EHR shows he was admitted to the facility on [DATE], he is [AGE] years old with a Brief Mental Status/BIMs score of 15. R4 has diagnoses not limited to cellulitis of left finger, methicillin resistant staphylococcus aureus infection, open wound of left thumb without damage to nail, homelessness, contact with and suspected exposure to other viral communicable diseases, and presence of cardiac and vascular implant and graft. On 12/23/25 at 2:58 PM, via telephone, R2 stated that twice in September, she was not given all required doses of her eye drops.On 12/30/25 at 12:30 PM, surveyor and V3 (Assistant Director of Nursing/ADON) reviewed R2 and R4's Medication Administration Record/MAR for September. V3 stated that daptomycin was not given to R4 on 9/28/25, and on 10/1/25. She also stated that R4 should not miss his antibiotic medication to ensure proper treatment of his infection. R2's eye drop (brimonidine tartrate) was not signed on 9/12/25, and 9/13/25, and when MAR is not signed, that means the medication was not given.On 12/30/25 at 1:07 PM, via telephone, V46 (Nurse Practitioner/NP) stated that she has been in the facility since June 2024, she is familiar with R4, and he was on daptomycin antibiotic intravenous/IV daily from 9/26/25 until 10/29/25. On 9/29/25, the pharmacy sent a memo that R4's insurance will not cover daptomycin without a prior authorization which she completed on 9/29/25, but it was still not approved so she ordered vancomycin as an alternative on 10/2/25 because that was when she was told that daptomycin was not approved. V46 stated R4 should not miss his antibiotic because it could worsen his infection.On 12/30/25 at 2:47 PM V49 (Registered Nurse/RN) has been in the facility for eighteen years, she works 3pm-11pm shift mostly on the first floor. Nurse should follow doctors order to maintain health of the resident. She stated the MAR should be signed once medication is given, if MAR is not signed it means the medication was not given. She stated she worked on 9/12/25 and 9/13/25 with R2, she does not know why she did not sign the MAR on both days for R2's eye drop (brimonidine tartrate). The potential effect of missing eye drops as ordered could increase R2's eye pressure. R2's Physician Order Sheet/POS active order as of 9/1/25 shows brimonidine tartrate ophthalmic solution 0. 15%, instill 1 drop in both eyes every eight hours related to glaucoma.R2's MAR showed missed doses of Brimonidine Tartrate on 9/12/25 at 6am, and on 9/13/25 at 10pm.R4's Physician Order Sheet/POS active order as of 9/26/25 shows daptomycin intravenous/IV solution, one time a day for thumb cellulitis until 10/29/25.R4's MAR showed daptomycin IV was not given on 9/28/25, 10/1/25, and 10/2/25 at 9am. Progress notes, R4 was transferred to the hospital on [DATE]. Registered Nurse and Licensed Practical Nurse Job description, document in part, Carry out medical providers orders according to the order and in accordance with local, state, federal, and facility policies and procedures. Policy on Administering Medication dated 9/2/25, document in part, medications are administered in a safe and timely manner, as prescribed.