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	05/29/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to a.) ensure a resident (R5) freedom of movement outside the facility by placing the resident on restricted pass privilege for no legitimate reason, b.) ensure Social Services department met regularly with one resident (R4), and c.) ensure proper staff, resident, and representative communication by not ensuring that all facility staff wear an identification badge. This failure has the potential to affect all 159 residents residing in the facility.Findings include: a. 5/27/26 at 9:57 AM, R5 said I have been at the facility for a year and eight weeks. R5 said the facility confused the whole situation regarding the red pass privilege. They confused me with another client. V32 (Social Worker) told me I was confused with another client with the same first name and I was taken off of red pass. I had to stay inside for two days. I felt my civil rights had been taken away. 5/28/26 at 12:07 PM, V13 (Social Services Director) stated in morning meeting, I heard R5 was put on red pass by the receptionist. I don't remember what receptionist. Receptionists do not have the authority to place residents on red pass. There is no documentation regarding the red pass situation. I apologized to R5 and explained it was an error in communication. The error was that the receptionist put R5 on red pass and R5 could not go out. This happened over the weekend and when I came in on Monday I was informed at my meeting and then I rectified it. I went to R5 that Monday and I told R5 they were not on red pass and that they were on green pass. Red pass means residents have broken a facility policy and are unable to go out without supervision. [NAME] pass can go out with or without supervision. I am not able to tell you why the receptionist put R5 on red pass. There is no documentation about this. It happened a month or two months ago. An order is needed from the physician to place on red or green pass. All residents have a standing order for supervised or unsupervised pass privilege. To my knowledge there was no order to place R5 on red pass because it was done by the receptionist who does not have authority. As far as I know the receptionist told R5 verbally they were on red pass. 5/28/26 at 1:45 PM, R5 said on 12/25/25, they came down to go outside to the store and the gym. The receptionist told them they could not go because they were on red pass. The receptionist did not know why. R5 went to V13 (Social Services Director), and they knew nothing about the red pass. R5 said they could not go out for 48 hours. 5/28/26 at 3:30 PM, V1 (Administrator) stated the receptionist was using some old pass list when they told R5 they were on red pass. The receptionist was not using the list updated by the social worker. R5 came to me to see why they were on red pass. I looked into it, and no one knew why R5 was red pass. It was changed to green pass immediately that same day that R5 came to me. R5 said that they were upset because they were not able to go out. I don't remember when this happened, but (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
	145648	A. Building B. Wing	05/29/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I know it was this year and more current than December. According to R5's Physician Order Summary Report, R5 has an active order that reads: May go out on pass unsupervised, order date 8/27/2025. According to R5's MDS (Minimum Data Set) 5/1/2026, R5 has a BIMS (Brief Interview for Mental Status) score of 15 indicating intact cognition. Facility Outside Pass Policy, 12/2016, documents in part: This organization is dedicated to providing residents with appropriate opportunities to remain engaged in the life of the community. One means of remaining connected involves leaving the facility grounds with an outside pass privilege (in most cases under the supervision and responsibility of a family member). b. R4 is a [AGE] year-old individual whose medical diagnoses in current face sheet includes but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unspecified abnormalities of gait and mobility, type 2 diabetes mellitus with hyperglycemia, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. R4's MDS (Minimum Data Set) section C- Cognitive Patterns documents R4's Brief Interview for Mental Status (BIMS)Score dated [DATE], documents R4's BIMS as 12/15, indicating R4 has moderate cognitive impairment. On 05/27/2026 at 10:10AM, V13 (Social Services Director) stated she is the social worker for R4. Social services are supposed to meet with a resident at least once every three months to assess their needs. The social services documents resident interaction in resident's health records under progress notes. V13 and surveyor reviewed R4's progress notes. Last Social Services (SS) meeting with R4 and her family was on 09/03/2025. V13 stated another meeting with SS should have been conducted. V13 stated SS meets with residents to discuss resident progress, medications, therapy, verify advance directives, diet, discharge plans and any other needs resident might have. V13 stated she has been too busy to meet with residents frequently. V13 stated if SS do not schedule resident meetings every quarter, resident needs will not be met. Residents can feel confused because of not have answers to their questions. Resident council meeting minutes document:03/20/2026 - Residents would like to see V13 and V37 (Psychiatric Rehabilitation Service Coordinator -PRSC) more around the floors. 04/24/2026-Residents would like to see V13 more often and available. 05/22/2026-Residents would like to see V13 on the floor or open window to talk to her due to being hard to find at times. R4's last Social Services progress note is dated 09/03/2025. Policy titled Social Work Department Policy dated 11.30.22 documents: The department shall, as necessary, work to support each resident's enhanced mental health through: (continued on next page)

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	05/29/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide individual support and attention based upon need. -Conducting rounds and wellness checks. c. On 05/27/2026 at 10:41AM, surveyor located on the third floor of the facility observes that V25 (Licensed Practical Nurse/LPN), V26 (Certified Nursing assistant/CNA), and V28 (Activity Aide) were not wearing a name tag or identification/ID badge. V25 states her ID badge is inside of her purse, V26 states her ID badge is inside of her locker, V28 states she lost her ID badge yesterday. V25, V26, and V28 state they should be wearing an ID badge. On 05/27/2026 at 10:58AM, surveyor located on the second floor of the facility observes that V24 (Registered Nurse/RN), V31 (Licensed Practical Nurse/LPN), V29 (Certified Nursing assistant/CNA), and V30 (CNA) were not wearing a name tag or identification/ID badge. V30 (CNA) states she has been working at the facility since 10/2025 and was never issued an ID badge in the facility. V31 (LPN) states he has been working at the facility for two years and has never issued an ID badge in the facility. On 05/27/2026 at 11:15AM, surveyor located on the first floor of the facility observes V40 (Licensed Practical Nurse/LPN), V20 (Certified Nursing assistant/CNA), V41 (CNA), V42 (CNA), V43 (CNA), V32 (Social Worker), and V22 (CNA) were not wearing a name tag or identification/ID badge. V40 (LPN) states she was never issued an ID badge in the facility. V41 (CNA) states the facility has not provided an ID badge for her in the facility. Facility census dated 05/26/2026 documents that 49 residents reside on the first floor of the facility, 60 residents reside on the second floor od the facility, 49 residents reside on the third floor of the facility, and R5 resides on the fourth floor of the facility. Facility Employee Handbook documents in part, Name badges are supplied by the facility and must be worn by all employees when on duty. Each employee is responsible for his/her name badge and must bear the cost of replacement if it is lost or misplaced. All employees are required to have and wear their ID cards at all times while at work.

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	05/29/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation, interview, and record review, the facility failed to provide adequate and clean linen for residents in the facility. This failure has the potential to affect all 209 residents residing in the facility. Findings include: On 05/27/2026 at 10:04AM, surveyor located on the fourth floor of the facility observes one linen cart in the hallway. The following items were observed on the linen cart: 0 wash cloths, 0 bath towels. V10 (Certified Nursing Assistant/CNA) states there is only one linen cart on the fourth floor. V10 states there is a drawer at the nurses' station where she keeps extra towels and linen for residents because the linen cart is not always fully stocked. Surveyor now located at the fourth-floor nurses' station with V10 and observes inside of a drawer the following items: 9 towels with 4 ripped/torn towels with frayed and tattered edges. Towels appear to be make-shift towels that were torn into smaller pieces to make more/extra towels. On 05/27/2026 at 10:26AM, R17 states sometimes when he asks the nursing staff for towels, he is told that there are none available. On 05/27/2026 at 10:41AM, surveyor located on the third floor of the facility and observes one linen cart in the hallway. The following items were observed on the linen cart: 0 wash cloths, 0 bath towels. V26 (Certified Nursing Assistant/CNA) states there is only one linen cart on the third floor. V16 (Laundry Aide) observed delivering linen to the third-floor linen cart. V16 observed placing towels onto the linen cart and then removing them and taking them to the third-floor nurses' station and placing them in a drawer. V26 states there is a drawer at the nurses' station where she keeps extra towels and linen for residents because there is a lack of towels in the facility. V26 states there are no clean linen storage closets on either floor in the facility. Surveyor now located at the third-floor nurses' station with V26 and observes inside of a drawer the following items: 16 towels with 14 ripped/torn towels with frayed and tattered edges. Towels appear to be make-shift towels that were torn into smaller pieces to make more/extra towels. Surveyor observes that the 3 towels are heavily stained. V26 then takes the 3 towels from the pile and states the towels are heavily stained and should not be in circulation for resident use. V26 states she will now put the towels to the side and give them to the housekeeping staff to use for cleaning. V26 states the stained towels should not have been stored in the linen cart or the drawer to be intended for resident use. On 05/27/2026 at 10:58AM, surveyor located on the second floor of the facility and observes four linen carts in the hallway. V29 (CNA) states there are a total of 5 linen carts on the second floor and one linen cart was taken down to the laundry room in the basement to be restocked. The following items were observed on linen cart #1: 6 heavily stained towels with ripped/torn, frayed and tattered edges. Towels appear to be make-shift towels that were torn into smaller pieces to make more/extra towels. The following items were observed on linen cart #2: 5 towels with ripped/torn, frayed and tattered edges. Towels appear to be make-shift towels that were torn into smaller pieces to make more/extra towels. The following items were observed on linen cart #3: 0 towels. The following items were observed on linen cart #4: 3 towels with ripped/torn, frayed and tattered edges. Towels appear to be make-shift towels that were torn into smaller pieces to make more/extra towels. On 05/27/2026 at 11:14AM, surveyor located on the first floor of the facility and observes five linen carts in the hallway. The following items were observed on linen cart #1: 0 towels. The following items were observed on linen cart #2: 0 towels. The following items were observed on linen cart #3: 0 towels. The following items were observed on linen cart #4: 0 towels. The following were observed on linen cart #5: 3 towels with ripped/torn, frayed and tattered edges. Towels appear to be make-shift towels that were torn into smaller pieces to make more/extra towels. V33 (Registered Nurse/RN) states the towels were probably cut to make more towels for the residents because the facility is low on towels. On 05/27/2026 at 11:49AM, V16 (Laundry Aide) states he has heard from staff that there are a lack of towels in the facility. V16 states he has also noticed that there are a lack of towels during washing and recirculating the linen. On 05/27/2026 at surveyor tours a linen storage room with V16 located in the basement. Surveyor (continued on next page)

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	05/29/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observes the following inside the storage room: 5 washcloths and 7 body towels with 3 towel having ripped/torn, frayed and tattered edges. Towels appear to be make-shift towels that were torn into smaller pieces to make more/extra towels. On 05/27/2026 at 11:53AM, V17 (Assistant Administrator) states V1 (Administrator) is responsible for ordering linen for the residents in the facility. On 05/28/2026 at 11:41AM, V1 (Administrator) states there is a warehouse that is attached to the facility's corporate office, and she has sometimes got linen from there for residents to use. V1 states she is unable to provide proof of this since she did not order the linen directly.On 05/28/2026 at 12:30PM, surveyor tours another linen storage room with V3 (Assistant Director of Nursing/ADON) located in the basement. V3 uses a key to gain access to this storage room. Surveyor observes the following inside of the storage room: 3 packs of new washcloths. V3 states 50 wash cloths are in each pack, which totals 150 wash cloths. V3 states she is aware of the quality of towels that are in circulation for residents' use and the facility is constantly ordering towels.Facility census dated 05/26/2026 documents that a total of 209 residents reside in the facility.Ombudsman Resident's Rights for People in Long-Term Care dated 11/2018 documents in part, Your facility must be safe, clean, comfortable and homelike.

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	05/29/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to (a) ensure one resident (R16) was free from abuse from a staff member; (b) failed to ensure that a resident (R2) was free from abuse from another resident. This failure resulted in R16 enduring psychosocial abuse and harm; R2 being confronted by another resident (R14) who had a box cutter in their possession, resulting in R2 leaving the facility against medical advice (A.M.A). Findings include: a. On 5/26/26 at 12:18 PM, R16, said this Saturday I got a visitor, my sister. We were going out on pass. I got it approved with V2 (Director of Nursing). My sister talked to someone about going out. I'm on red pass because I was late coming back from out on pass. So, I can't go out by myself until tomorrow when my red pass is over. I can go out with family. My sister is my #1 emergency contact. I was at the front desk doing paperwork to go out. I was leaving the building. V39 (Social Service Coordinator) comes in saying They aren't leaving the building. I'm getting it (the pass) unapproved. My sister came inside. V39 said I don't need to be here, take them home with you we don't want them here. V39 started yelling at other residents to get out of their way. When V39 was yelling at V23 (Receptionist) and other residents I said to stop yelling at them if you have a problem with me. V39 said to shut up b**** to me. My sister was saying stop talking to me like that. Stop being rude to these residents. You are unprofessional. V2 came and said to go on visit. My sister and I left. I am here for brain aneurysm. I have been here since September 2025. On 5/27/26 at 12:57 PM, V23 (Receptionist) stated I was at the receptionist's desk. I document every resident that comes and goes. An incident took place that should not have taken place. The incident occurred on a Saturday after 2 PM. R16 came to me excited to be going out with their sister and nephew. I called V2 (Director of Nursing) to verify that R16 was going out. I got the release form for the person picking up R16 to complete. V39 (Social Service Coordinator) walks in and starts yelling that R16 is on red pass. V39 comes behind the reception desk, gets on my computer, and starts yelling at R16. That R16 can't go out. R16's sister, who is also an emergency contact, comes into the building. V39 was yelling at the emergency contact. I called a code gray which means an incident/altercation that's happening. Staff showed up. V39 was still yelling at R16 and then started yelling at R16's sister. R16 started crying. V39 was telling R16's sister that when R16 goes out they come back with something insinuating contraband. I called another code gray so another team would come. The current team was in shock wondering what was going on because it was a staff person not the resident that I called for. When I called for the second code grey I inadvertently turned on the intercom, so part of the incident was heard throughout the facility. Residents were lined up to get me to write their names down to go out at the same time. V39 yelled at the other residents What are you waiting on. One resident told V39 they were waiting for a cigarette. V39 was focused on R16. That incident should not have happened. It was heartbreaking. It was sad. I told V39 they were unprofessional and V39 told me I was unprofessional. V39 told me I'm not supposed to be there for the residents. Staff should not be yelling at residents. This is the resident's home. It was inhumane. R16 was being hurt and attacked for no reason. It is a form of abuse. I was upset by the incident. V39 disrespected everybody including myself and the resident. I did not hear mention of a gun from V39. R16 was red pass which means the resident cannot go out by themself. The resident can go out with an escort. I have to know who the resident is going with, and I notify management. (continued on next page)

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	05/29/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/28/26 at 10:10 AM, V2 (Director of Nursing) stated I was here on the Saturday of the incident. R16 came to my office happy to go out on pass with their sister. R16 is on a red pass so I confirmed with V32 (Social Worker) and with V1 (Administrator) that R16 could go out with their sister. V1 and V32 both gave the okay for R16 to go out on pass. I notified V23 (Receptionist) that R16 could go out. I told V23 as long as R16's sister signed them out it is no problem. R16 came to my office and told me that they were waiting at the front desk to go out when V39 (Social Service Coordinator) came into the facility and said they could not go because they were on red pass. I went into the hallway, and I told V39 that as long as R16's sister will sign them out they could go. I went back to my office and then heard a code gray called, which means a behavior with a patient. I went to the lobby and R16's sister was yelling at V39. V39 was explaining that they were verifying that they are the sister and on the face sheet. I think R16's sister was upset because there was a kid in the car, so they were in a hurry. V39 told me that they were checking the face sheet to verify the sister's identity. V39 is new to the facility. V39 has been here for about a month. V39 works in the afternoon, 3 PM-11 PM, and handles the whole building. R16 and their sister left. I told V39 to leave the building for the day because I wanted to investigate what happened. I called V1 (Administrator), the Abuse Coordinator. I was told that V39 was yelling at R16's sister. When I got to the front it was V39 and R16's sister exchanging words and it was loud, voices were raised. I did not hear V39 cussing. R16 was visibly upset, mad and shaking and had a red complexion. R16 was so happy to be going out. V39 is suspended. We do abuse in-services with all staff after an incident and at least every three months. We educate new hires on abuse. On 5/28/26 at 3:30 PM, V1 (Administrator) stated I am the Abuse Coordinator. I offer abuse training and in-services to all staff usually every three to six months and upon hire. R16 was on red pass. R16 had made arrangements for their sister to pick them up. R16 was at the front desk when V39 (Social Service Coordinator) came in. V39 was saying R16 could not go out because R16 was on red pass so R16 was getting upset. V39 text V3 (Assistant Director of Nursing) and was informed to get a copy of the family members' identification. R16's sister admits they were swearing and were loud. They said it was loud. R16's sister didn't feel that V39 was professional. It was a heated argument. R16 and their sister left. During this time the code gray was called due to the argument and inadvertently the intercom was turned on so the whole facility heard the commotion. There were residents in line at the front waiting to get cigarettes. According to R16's face sheet, R16 is a [AGE] year-old resident of the facility. R16 has diagnoses that include but are not limited to aneurysm of other precerebral arteries; type 2 diabetes mellitus; generalized anxiety disorder. According to R16's physician order summary report, R16 has an active order that reads: May go out on pass supervised, order date 5/18/2026. According to R16's MDS (Minimum Data Set) 3/20/2026, R16 has a BIMS (Brief Interview for Mental Status) score of 15 indicating intact cognition. Facility Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, no date, documents in part: Residents have the right to be free from abuse, neglect, misappropriation of property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by (continued on next page)

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	05/29/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	anyone including, but not necessarily limited to: a. facility staff. b. Facility Reported Incident (dated 03/08/2026) documents in part: It was reported that residents, R14 and R2, were in a verbal altercation and started to threaten each other. Separated immediately. Both residents were assessed, no injuries noted on both residents. Both residents were separated immediately by staff. Assessment done to both residents no injury noted. Notifications made. Police notified. MD notified. R2's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Urinary tract infection, intestinal obstruction, other neoplasms of uncertain behavior of lymphoid, generalized anxiety disorder. Minimum Data Set Section (MDS) section C (dated 12/14/2025) documents that R2 has an Interview for Mental Status (BIMS) score of 15, indicating that R2's cognition is intact. A care plan (dated 12/09/2025) showed that R2 has a history of alcohol abuse. This appears related to maladaptive coping skills and ambiguity toward recovery. R2 has been educated on facility policy prohibiting the use of non-prescribed substances. R14's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Chronic obstructive pulmonary disease, schizophrenia. Minimum Data Set Section (MDS) section C (dated 05/05/2025) documents that R14 has an Interview for Mental Status (BIMS) score of 14, indicating that R14's cognition is intact. Care plan (dated 03/19/2026) documents that R14 is challenged by mental illness and/or dementia and experience psychosis: Hallucinations -Command - Auditory and/or Delusions. R14 is noted to respond and react to internal stimuli and present with disorganized/chaotic thinking which distorts my perception of reality. On 05/27/2026 at 9:53AM, V10 (certified nursing assistant) stated, Both R2 and R14 said that they were in line to smoke. They were on the first floor. And then I don't know what R14 thought that he heard R2 say to him. That's when R14 pulled out a knife and said that he was going to kill R2. That's when R2 started screaming that R14 has a knife and that he's trying to kill R2. That's when V11 (activities director) came out to see what's going on. And after that I am not sure. I don't know if he hid the blade and said that R14 did not do anything. I heard about the incident from V11 (activities director). After that happened, they both went outside to smoke. And then they went upstairs and that's when V11 let the nurse and me know what happened. I think the nurse was V12 (licensed practical nurse). V12 works every Sunday. That' s when R2 called the police and said that R2 feels unsafe. On 05/27/2026 at 6:55PM, V12 (licensed practical nurse) stated, I was informed that whatever happened, happened on the first floor, when R2 and R14 were waiting for the smoke break. Some people say that they were waiting in line to smoke, and some people say that it happened on the patio. The police were called. I really don't know what exactly happened. R2 said that he was threatened by R14. I don't know who threatened who exactly. I can't remember if I was the nurse on that day. I don't remember who reported this incident to me, I really don't recall. On 05/27/2026 at 7:10PM, V9 (licensed practical nurse) stated, Pertaining to the incident on (continued on next page)

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	05/29/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	03/08/2026, I am not aware of what happened, I came in towards the end of the incident, after the code was called. This was on the actual smoking patio. R14 had a box cutter. R14 was already upset because he had a red pass, and he could not go outside to smoke in front. The code was called, and I responded to the code. The box cutter was taken when I went to search R14's room. There were no injuries. R14 was leaving the patio when the code was called, and he went to his room. We went up to his room and took the box cutter away. R14 did not try to fight, R14 gave the box cutter willingly. R2 and R14 were separated immediately. R2 felt threatened. R2 has a very paranoid demeanor. R14 goes out into the community independently. The police were called. R14 was taken away by the police, and R14 was later brought back to the facility. R14 goes out into the community and that is how he was able to get a box cutter. R2 and R14 were separated on different floors. R14's room was searched to make sure that he does not have any other weapons, and R14 was placed on the red pass. On 05/28/2026 at 9:02AM, V2 (director of nursing) stated, I think the incident between R2 and R14 happened at night. I think that they notified V1 (administrator) about it. I can't remember the details. There was a misunderstanding on the patio. As far as I can remember, the residents live on different floors. One of them was talking to themselves, and the other resident thought that the other resident was talking to him. I think that R2 was the one that called the police. There was nothing physical. R2 thinks that he was threatened, and he called the police, and the police picked up R14. I did not see a knife, it's like a letter opener. R2 was insisting that he was threatened. I'm not sure but R2 called the police because he was threatened. It's a box cutter. R14 goes out and he has a green pass. I think that R14 is on green pass. A green pass is a privilege for the residents. They know that they cannot have anything on them. R14 was re-admitted to the facility on [DATE] from the police station. After that incident there were no other behaviors from R14. R14 is still insisting that he did not do anything. R14 has auditory hallucinations. When R14 came back to the facility, the doctor ordered to increase Seroquel to 400mg. Since then, R14 has not exhibited any other behaviors. R14 was not supposed to have this box cutter. We discourage the residents from having any sharp objects such as scissors. R14 did not try to stab R2 with the box cutter. R14 is appropriate for this facility. R14 gets along with other residents. R14 was expressing that it's not a weapon, that he did not do anything wrong. After the incident, R2 expressed that he does not feel safe. R2 lives on another floor. I think that R2 wanted to leave the facility. If we placed R2 in a room with another resident, he wanted another room. I accommodated R2 many times with a room change. R2 wanted to change rooms as soon as he got a roommate. R2 did not feel comfortable with having roommates. According to the psych doctor, he documented that R2 has generalized anxiety disorder, and aggressive behavior. R2's BIMS score is 15, and has a green pass. R2 left against medical advice (AMA) on 03/12/2026. R14 has COPD, schizophrenia, schizo-affective disorder, bipolar type. R14's BIMS score is 14. R14 was sent out to the hospital for behaviors on 09/16/2026, and at that time he was new to the facility, and maybe he was still adjusting. R14 was gone for a week that time, and since that time, he has not been sent out to the hospital. During the incident, R14 didn't really know what happened, because he wasn't trying to fight with R2 at all because R14 was talking to himself. We perform random room searches for R14, especially because R14 does out into the community. No other residents expressed having concern for their safety. We have not found any sharp objects on R14 since then. We even remove On 05/28/2026 at 11:45AM, V1 (administrator) stated, On 03/08/2026, R2 and R14 were in the smoke like. R2 was talking to himself constantly. R14 thought that R2 was talking to him. It was standard for R2 to talk to himself. They started arguing because R14 thought that R2 was talking to him. They were arguing with each other. We looked at the cameras and there was no physical contact between R2 and R14. We separated them and it turned out that R14 had a box cutter in his pocket. R14 had a box cutter because he was getting a lot of packages. R14 said that he bought the box cutter at Walgreens. R14 was arrested. When I reviewed the video, I did not see R14 taking out his box cutter. (continued on next page)

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	05/29/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The box cutter remained in his pocket. The police were called, and they searched R14 and found the box cutter in his pocket, and he was arrested. R14 had the box cutter because he gets a lot of packages, and that's why he had the box cutter, that's what he bought it for. R14 never intended for the box cutter to be a weapon. The police did not inform us, and they brought him back to the facility. It was a few days later. R2 had come to me and told me that he was unhappy that R14 was back. R2 and R14 were living on separate floors, but obviously, they smoke outside and they can run into each other on the smoking patio. I informed R2 that they were on separate units. R2 was screaming at me. I asked R2 if he wanted to go to another facility, and he said no. R2 said that he wanted to sign out against medical advice (A.M.A). To ensure the safety of other residents, R14 was having room checks for a while. R14 still receives random room checks. The only thing that we found was a cigarette. R14 does not believe that he has mental illness. There have been no behaviors seen since then. I am the abuse coordinator. All employees receive abuse prevention training. When there is a report of a resident having a sharp object, we perform a room search right away. There have not been any issues with residents having sharp objects. We also search the residents with their consent. Surveyor interviewed R4. On 05/28/2026 at 12:10PM, R4 stated, R14 stated that he was done smoking and as he was walking back inside, R2 was cursing. R14 said that he asked R2 who he's talking to and R2 responded that he was talking to R14. R14 stated that R14 and R2 started to argue and R14 took out a box cutter that he had in his pocket. R14 stated that he did not attempt to stab R2 and he kept the box cutter on his side at all times. R14 stated that R14 has good vision in one eye, and he cannot afford to get hit and lose sight in that good eye. R14 stated that there was no contact made between R2 and R14. R14 stated that he went up to his room and staff arrived and asked him for the box cutter which R14 gave willingly. R14 stated that police arrived and arrested R14 and R14 spent the night in jail. R14 stated that he does not have any sharp objects on him. R14 stated that R2 was always talking to himself and cursing and R14 never started problems with R2. R14 stated that he took the box cutter out from his pocket in case R14 would get attacked. R14 stated that he had the box cutter on him just because it's a tough neighborhood and R14 goes out. R2's Progress Note (dated 03/12/2026) documents, Writer was notified by staff that the resident called the police. Writer observed three officers in the lobby area. According to the officer, the resident called to express his concern about safety and desire to sign an AMA. Social Service present at the time. R2's Progress Note (dated 03/12/2026) documents, Resident verbalized desire to leave the facility against medical advice (AMA). Resident stated he did not feel safe remaining in the facility and contacted local police independently to report this concern. Police responded to the facility and spoke with the resident. Resident assessed and found to be alert and oriented ×3 (person, place, and time). Resident able to communicate needs clearly and demonstrated understanding of the situation and potential risks associated with leaving the facility. Resident was informed of the risks of leaving the facility AMA and was educated regarding the benefits of continuing care and supervision. Resident verbalized understanding of the information provided and continued to request discharge. Resident was offered the option to transfer to an alternative facility if he did not feel comfortable remaining at the current location. Resident declined this option and continued to request to leave. Director of nursing and administration notified. Resident provided with AMA documentation and discharge information. Resident elected to proceed with leaving the facility. Resident discharged from facility per his request. R14's Progress Note (Dated 03/10/2026) documents, During the shift the resident was readmitted to the facility at 12:43pm, he was transported by a uber. A full head toe assessment was completed. (continued on next page)

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	05/29/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	There were no injuries, trauma, abrasions, scratches, bruises or wounds visible. The residents VS WNL there were no signs of discomfort observed, he was able to verbalize his needs, all his needs were met. His call light was placed Within reach. Nursing staff to continue to monitor. Director of nursing was notified. R14's Progress Note (dated 03/11/2026) documents, Upon resident's permission, a search of resident's belongings and living area was conducted on 3/10/2026. There were no prohibited/unauthorized items found. The facility prohibited/unauthorized items policy was reviewed again with resident and copy given so that resident is fully aware of all obligations. Resident was re-educated on matters of safety and what steps are taken to minimize risk. The resident verbalized an understanding. Abuse, Neglect, Exploitation and Misappropriation Program Policy (undated) states in part: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Protect residents from any further harm during investigations.

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	05/29/2026

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 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. Based on interview and record review, the facility failed to report to the State Agency a suspicion of abuse involving one (R16) of three residents in a sample of 17 residents.Findings include:On 5/26/26 at 12:18 PM, R16, said this Saturday I got a visitor, my sister. We were going out on pass. I got it approved with V2 (Director of Nursing). My sister talked to someone about going out. I'm on red pass because I was late coming back from out on pass. So, I can't go out by myself until tomorrow when my red pass is over. I can go out with family. My sister is my #1 emergency contact. I was at the front desk doing paperwork to go out. I was leaving the building. V39 (Social Service Coordinator) comes in saying They aren't leaving the building. I'm getting it (the pass) unapproved. My sister came inside. V39 said I don't need to be here, take them home with you we don't want them here. V39 started yelling at other residents to get out of their way. When V39 was yelling at V23 (Receptionist) and other residents I said to stop yelling at them if you have a problem with me. V39 said to shut up b**** to me. My sister was saying stop talking to me like that. Stop being rude to these residents. You are unprofessional. V2 came and said to go on visit. My sister and I left. I am here for brain aneurysm. I have been here since September 2025. On 5/27/26 at 12:57 PM, V23 (Receptionist) stated I was at the receptionist's desk. I document every resident that comes and goes. An incident took place that should not have taken place. The incident occurred on a Saturday after 2 PM. R16 came to me excited to be going out with their sister and nephew. I called V2 (Director of Nursing) to verify that R16 was going out. I got the release form for the person picking up R16 to complete. V39 (Social Service Coordinator) walks in and starts yelling that R16 is on red pass. V39 comes behind the reception desk, gets on my computer, and starts yelling at R16. That R16 can't go out. R16's sister, who is also an emergency contact, comes into the building. V39 was yelling at the emergency contact. I called a code gray which means an incident/altercation that's happening. Staff showed up. V39 was still yelling at R16 and then started yelling at R16's sister. R16 started crying. V39 was telling R16's sister that when R16 goes out they come back with something insinuating contraband. I called another code gray so another team would come. The current team was in shock wondering what was going on because it was a staff person not the resident that I called for. When I called for the second code grey I inadvertently turned on the intercom, so part of the incident was heard throughout the facility. Residents were lined up to get me to write their names down to go out at the same time. V39 yelled at the other residents What are you waiting on. One resident told V39 they were waiting for a cigarette. V39 was focused on R16. That incident should not have happened. It was heartbreaking. It was sad. I told V39 they were unprofessional and V39 told me I was unprofessional. V39 told me I'm not supposed to be there for the residents. Staff should not be yelling at residents. This is the resident's home. It was inhumane. R16 was being hurt and attacked for no reason. It is a form of abuse. I was upset by the incident. V39 disrespected everybody including myself and the resident. I did not hear mention of a gun from V39. R16 was red pass which means the resident cannot go out by themself. The resident can go out with an escort. I have to know who the resident is going with, and I notify management.On 5/28/26 at 1:55 PM, V1 (Administrator) stated I did not do a reportable because the incident with R16 was between the R16's family member and V39 (Social Service Coordinator) and V23 (Receptionist) and V39 had words. I'm still investigating. I have interviewed V39, R16's sister, R16, V23, a housekeeper and V2 (Director of Nursing).Facility Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, no date, documents in part: 7. Investigate and report any allegations within timeframes required by federal requirements.