

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Landmark of Lincoln Park Rehabilitation and Nursin		STREET ADDRESS, CITY, STATE, ZIP CODE 735 West Diversey Chicago, IL 60614	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide nail care and shave one (R2) of four (R1, R6, R7) residents reviewed for ADL's (Activity of Daily Living). Findings Include: R2 was admitted to the facility on [DATE] with diagnosis not limited to Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Acute Embolism and Thrombosis of Unspecified Deep Veins of Lower Extremity, Bilateral, Schizoaffective Disorder, Bipolar Type, Anxiety Disorder, Major Depressive Disorder, Psychosis, Paralytic Gait, Lack of Coordination, Abnormalities of Gait and Mobility, History of Falling, Muscle Weakness (Generalized), Weakness, Pain in Right Lower Leg and Gastrointestinal Hemorrhage. R2's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 14 indicating intact cognitive response. R2's Care Plan document in part: Focus: I have or am at risk for a Self-Care Deficit and requires/potentially requires assistance with ADLs to maintain the highest possible level of functioning. Interventions: Provide assistance with all ADLs as required per my dependence needs Personal Hygiene. MDS Section GG - Personal Hygiene (Substantial/maximal assistance). Foot and Ankle Clinic note dated 02/24/26 document in part: The patient was evaluated bedside today for elongated toenails and a foot check. The patient would like toenails trimmed today. Toenails are elongated and dystrophic with subungual debris x10 and pain on palpitation. Onychomycosis x10. Treatment: the patient was seen, evaluated and treated at bedside. All elongated nail margins were trimmed. Skin/Shower Worksheet dated 02/11/26 V25 (Certified Nurse Assistant) documented in part: Type of Condition: 22. Long Toenails (toenail request). Skin/Shower Worksheet dated 02/14/26 V26 (Certified Nurse Assistant) documented in part: Type of Condition: 22. Long Toenails. Skin/Shower Worksheet dated 02/18/26 V24 (Certified Nurse Assistant) documented in part: Type of Condition 15. Nail beds. 22. Long Toenails. On 03/03/26 at 09:37 AM V6 (Hospital Social Worker) stated I went to assess R2, and he was dischuffed with long facial hair and fingernails. The physical therapist said R2's feet looked to be in poor condition with long toenails. The primary concerns were R2's hygiene. R2 said that he used to have an electric razor but dropped and broke it and the facility will not let him use disposable razors. On 03/03/26 at 01:47 PM R2 call light was activated upon entering R2's room. R2 was observed lying in bed with a long unshaven beard and mustache. Surveyor asked R2 when was the last time that he had been shaven. R2 responded it's probably been 2 months since they have shaved me. I asked my aide and I have requested to be shaved. On 03/03/26 at 02:02 PM When V7 (Certified Nurse Assistant) turned R2 in bed the fitted sheet underneath R2's body was observed to be yellowish and unclean with multiple small dark particles observed. V7 stated it has been a while since R2 has been up out of the bed. Surveyor asked V7 if R2's fitted sheet looked like it had been changed. V7 responded, looking at that sheet nope, not at all. On 03/05/26 at 1:39 PM V7 (Certified Nurse Assistant) stated From what I remember R2's mustache and beard were kind of grizzly; it was not trimmed and neat when he went to the hospital. On 03/05/26 at 02:17 PM V26 (Certified Nurse Assistant) stated I took care of R2 as soon as R2 came back from the hospital. R2's fingernails were probably beyond his skin. We did an assessment and there was a lot of black dried material on R2's fingernails. R2 told me it was poop. When R2 was vomiting they sent R2 right out to the hospital. R2's beard was not too long. In January I (continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>cut R2's beard and mustache but it had grown back. I would say it looked grizzly and not well maintained. R2 kept saying that he wanted his fingernails clipped. On 03/05/26 at 02:01 PM V25 (Certified Nurse Assistant) stated R2's toenails were long. I do not cut the toenails, the podiatry lady is supposed to cut them, but it is based on whoever is on the podiatry list. I don't want to lie but R2's toenails were long, and his toes were aching him. On 03/04/26 at 09:29 AM V10 (Certified Nurse Assistant) stated R2 asked me to cut his hair but his clippers were not working because somebody had dropped them, and a piece had come out. R2's mustache and beard were long and thick. V10 showed this surveyor a white disposable razor and said these are the razors we got, and they don't work. I did not want to, but I cut R2's mustache and beard down as much as I felt comfortable cutting. We usually have a barber, and they use to come once a month. R2 wants the facial hair all the way off but we don't have the clippers. V9 (Licensed Practical Nurse) told me to cut R2's fingernails last week. On 03/04/26 11:19 AM V2 (Director of Nursing) stated the certified nurse assistants are responsible for shaving R2's face. We use disposable razors. They have a barber, but the resident has to pay for the barber services. On 03/04/26 at 12:46 PM V2 (Director of Nursing) stated R2 has a goatee/beard and mustache. Certified nurse assistants are trying to cut R2's hair and trim his mustache and beard. On 03/05/26 at 02:49 PM V2 (Director of Nursing) stated When R2 returned from the hospital they came and got me because they thought it was blood under and on R2's fingernails. V26 (Certified Nurse Assistant) thought something was going on with R2's fingernails. It was from the vomitus, and they brought R2 back from the hospital with the coffee ground emesis. R2's fingernails were trimmed to get the brown stuff from under R2's fingernails the day that R2 came back to the facility. On 03/05/26 at 09:20 AM R2 was observed lying in bed. R2 stated I am doing okay. They shaved me yesterday and I feel a lot better because I felt depressed. Policy: Titled Guidelines for A.M. care in preparation for the activities of the day. Equipment: Make-up or shaving equipment. Procedure: 12. Clean area under fingernails and maintain nails at a smooth/safe length. Titled Resident Rights undated document in part: As a resident of this facility, you will have the right to a dignified existence and to communicate with individuals and representatives of choice. Accommodation of Needs: You have the right to receive services with reasonable accommodations to individual needs and interests.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain a complete and accurate medical record for one (R3) of six (R1, R2, R4, R5, R6) residents sampled for record review. Findings Include: Based on interview and record review the facility failed to maintain a complete and accurate medical record for one (R3) of six (R1, R2, R4, R5, R6) residents sampled for record review. Findings Include: R3, formally known as R1, is the subject of this complaint being investigated for the allegation of Administration/Personnel. Three (R2, R4, R6) additional residents were reviewed for Administration/Personnel with no concerns. R3 was admitted to the facility on [DATE] with diagnosis not limited to Centrilobular Emphysema, Hypothyroidism, Nephropathy, Liver Disease, Abnormalities of Gait and Mobility, Weakness, Anemia, Pure Hypercholesterolemia, Primary Insomnia, Constipation, Fall, Nasal Congestion and Nicotine Dependence. R3's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. R3's hospital records upon admission to the facility dated 12/13/23 document in part: Histories: Social History [NAME] Use: Smoking status: Some Days Types: Cigarettes. Social History and assessment dated [DATE] document in part: 9. Addictive Behavior: a. Is there a history with alcohol, street drugs, prescription over-the-counter drugs, nicotine/tobacco? No. c. Current use of smoking products? No. CT (Computed Tomography) Chest Lung Screening without Contrast dated 12/02/25 document in part: Nicotine Dependence, cigarettes, in remission. R3's Face Sheet and Medical Records Diagnosis Information document in part: Nicotine Dependence, Unspecified, Uncomplicated. Onset date: 12/21/25. Face Sheet present to the surveyor on 03/05/26 document in part: Diagnosis Information Nicotine Dependence, Cigarette in remission onset date 08/12/25. On 03/03/26 at 12:57 PM R3 stated F17.211 is the code for nicotine dependent in remission. I want them to put the right code in the proper area. I am trying to transition out of here and a lot of places do not accept anyone that smokes. I have not smoked since October 2023. On 03/04/26 at 11:19 AM V2 (Director of Nursing) stated R3's pulmonary paperwork has nicotine dependent and for assistant living R2 wants to have it taken off. The doctor will meet with her to resolve it. On 03/04/26 at 01:54 PM V15 (Former Nurse Practitioner) stated R3's diagnosis should be carried over from the resident's hospital stay and should be updated to manage the new problem. On 03/05/26 at 09:33 AM V18 (MDS Coordinator) stated I usually do the diagnosis when a resident is admitted or readmitted. Medical records upload the record, and I would have to wait until they are uploaded. The medical doctor and nurse practitioner also add diagnosis. I was here when R3 was admitted to the facility. We enter the diagnosis from whatever is on the hospital records. R3 makes her own appointments so it is hard to keep track. I did not know about R3 going to another hospital. The diagnosis should have been updated if I was aware of the appointment. I was aware that the nurse practitioner had inputted the nicotine diagnosis. The diagnosis should have been coded in remission instead of dependence. I was made aware yesterday when V15 (Former Nurse Practitioner) reviewed R3's records. I resolved the other diagnosis and input the correct diagnosis in R3' medical record. If the diagnosis is not updated there is a potentially that it will affect the resident's treatment, depending on the diagnosis. I have never known R3 to smoke and I did not know the diagnosis was there and inputted by the nurse practitioner. On 03/05/26 at 10:11 AM V18 (MDS Coordinator) presented the surveyor with a copy of R3's Face Sheet with the updated diagnosis: Nicotine Dependence, Cigarettes, in Remission. On 03/05/26 at 02:49 PM V2 (Director of Nursing) stated We were not aware of R3's CT (Computed Tomography) chest. R3 makes her own appointments and gives the records to my medical record lady, I did not even know. R3 has paperwork with other doctors, and it is confusing when she has multiple doctors with different diagnosis. R3 said I am trying to go to this assistant living and how does she get the pulmonary nicotine dependence diagnosis off her medical record. That was the doctor that input that diagnosis in R3's medical record (continued on next page)</p>		

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