STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145654	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Lincoln Park Rehabilitation and Nursin	735 West Diversey Chicago, IL 60614

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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 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assure that a resident was free of unnecessary physical restraints; failed to identify the specific medical symptoms warranting the use of a physical restraint and failed to obtain physician orders with medical justification. This failure affected one resident (R4) out of five residents reviewed for abuse who was restrained by being placed in a Geri-chair with a sheet tied over the resident's body, restricting the residents ability to freely ambulate and causing bruising to the resident's body; with no physician order, no consent/permission, and no medical justification.Findings Include:R4's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Type 2 diabetes mellitus with hyperglycemia, chronic obstructive pulmonary disease, hypertensive heart disease without heart failure, hyperlipidemia, urinary incontinence, edema of unspecified eye, bipolar disorder. Minimum Data Set Section (MDS) section C (dated [DATE]) documents R4 has an Interview for Mental Status (BIMS) score of 9, indicating R4 has moderate cognitive impairment.MDS Minimum Data Set section GG (dated 03/24/2026) documents R4 requires supervision or touching assistance with (a) Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and (b) walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space and (c) Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns and (d) Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space and (e) R4 does not use a wheelchair and/or scooter. Care plan (dated 03/11/2026) documents R4; ABUSE	NEGLECT	EXPLOITATION	TRAUMA SIGNIFICANT R1 is an adult living with chronic health conditions and co-morbidities requires the support, services and structure of this care setting to maintain stability and highest practicable level of functioning. It is recognized living with chronic medical/psychiatric illness, physical decline, the pandemic, and requiring LTC (Long Term Care) may be viewed as a form of trauma, although maintains not having been the perpetrator and/or recipient of mistreatment, abuse, neglect, and/or exploitation.R4's Final Facility Incident Investigation Report (dated 03/16/2026) documents in part: The facility investigated the 03/10/2026 facility reported incident. Through the course of the investigation the facility determined R1 was physically restrained in a Geri chair (specialized chair) using a sheet. The sheet was positioned around the resident's lap and back of the chair with the resident's arms and legs free. This was identified and reported to a licensed practical nurse (L.P.N) by the day shift certified nursing assistant (C.N.A) who reported for duty 03/10/2026 at 7:00 AM. The C.N.A assisted the resident from the Geri chair and provided incontinence care. Upon notification the administrator immediately began an investigation. The investigation included interviews with employees, residents and review of camera footage. The alleged wrongdoer and other employees potentially having knowledge of the occurrence were suspended throughout the course of the investigation. No employee involved or potentially having knowledge of the occurrence has worked in the facility during the course of this investigation. Employees remain suspended and terminated. The resident could not provide meaningful information when interviewed and was unable to provide a statement. On 03/27/2026 at (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	10:03 AM, V1 (administrator) stated, On 03/10/2026, during a morning meeting, I was informed by V7 (wound care nurse) that V6 (certified nursing assistant) shared with her they found R4 in a Geri chair tied with a sheet. We stopped the morning meeting, and we immediately called V6 down. We had V6 explain what she encountered when she came in. V6 explained she received R4 in a Geri chair, with the sheet tied. V6 said she called the supervisor, V8 (licensed practical nurse/house supervisor), to notify V8 of what she encountered when she came in. At that point, I initiated a report of the abuse allegation to the state agency (Illinois Department of Public Health). I went to the scheduler to find out who else worked on the night shift, 11:00PM to 7:00AM on 03/09/2026 into 03/10/2026. I began making phone calls, to find out each of the aides and nurses were assigned to floor. Then we instructed the morning shift nurse assigned to R4 to make a head-to-toe assessment. Social service went up to see the resident. I continued to make phone calls to obtain the staff statements. V2 (director of nursing) and I, went to check the security footage and we did see that R4 sitting in the hallway in the Geri chair with the sheet tied over R4's lap. The Geri chair is considered a restraint because the Geri chair is not assigned to R4. The sheet is also a restraint because it was tied over R4's lap. R4 is mobile and does not use a chair or any other devices. We went through and suspended the staff. V6 was also suspended because V6 did not notify me. I am the abuse coordinator and per the abuse prevention protocol, staff are required to notify me, the abuse coordinator. There was a total of 7 employees suspended. V6 was suspended for not notifying the abuse coordinator directly, because she was aware at 7:00AM. V7 was suspended because she failed to notify the abuse coordinator, as she was notified by V6 at 9:00AM. V7 did not notify me until about 10:45AM. V8 was suspended because she failed to notify me. V6 had notified her at 7:00AM, and V8 never notified me at all. V9 (licensed practical nurse) was suspended. V9 was the nurse assigned to R4 during the night shift. V9 said he did not know anything about the sheet being tied over R4, but he was aware R4 was in the Geri chair. V10 (certified nursing assistant) was suspended. She was the C.N.A working evening as well. V10 stated V10 saw R4 in the Geri-chair. V11 (certified nursing assistant) was suspended. R4 was a part of V11's assignment evening. V11 was suspended for not rounding on her assigned residents. V11 stated she saw R4 in the chair and walked past her several times. V11 stated she did not tie R4 to the chair. V12 (Certified Nursing Assistant) was suspended for using a sheet to keep a person from climbing in and out of the chair. V12 was the aide who placed R4 into the Geri-Chair. We proceeded to have social services conduct a resident interview to make sure everyone feels safe. We used a form to ask the residents if anyone caused them any harm, if they feel afraid or embarrassed since they have been here, and if they ever witnessed any other resident being treated or spoken to in a matter that was unacceptable. We also proceeded with in-services on the abuse policy and who to report to when staff see abuse or hear of abuse when it is reported to them. I notified the physician of the abuse of R4 being found in a Geri-chair with the sheet tied. V2 notified the family. The police were called and notified. The police report number is available. V7, V8, V9, V10, V11 and V12 were terminated. V6 was brought back with education to remind her abuse needs to be reported directly to the abuse coordinator. V9, the nurse assigned to the resident was not rounding on his residents. V9 stated he did not know a Geri-chair was a restraint when a Geri-chair is not assigned to them. At 2:29PM, V1 (administrator) stated,R4 was untied and removed from the chair around 7:10AM or 7:15AM, because V6 (certified nursing assistant) said she was doing her rounds and V6 removed R4 from the chair, and got R4 up to the bathroom. On 03/27/2026 at 11:21AM, surveyor observed R4 sitting in the 3rd floor dining room. R4 was observed to feel safe. R4 was observed clapping her hands and listening to music during resident activities. R4 stated she was doing fine. R4 was not able to recall the events that occurred during the incident on 03/10/2026. On 03/27/2026 at 1:03PM, V12 (certified nursing assistant) stated, On 03/10/2026, I was not assigned to R4, but I was a witness there. R4's room was on the third floor. R4 was in a Geri-chair, and she had a sheet around her waist that was tied. R4 does not utilize a Geri-chair. R4 walks, moves her arms around and is very alert. R4 was able to move her arms and legs. The sheet was used as a seat belt. No, we cannot use a (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	sheet and tie it over residents. Wheelchairs don't even come with seat belts. It is not allowed because tying a sheet over a resident who does not use a Geri-chair is a restraint. I thought it was a safety precaution. I thought it was for safety and R4 does go to different rooms. I did not do anything because I thought it was a safety measure. R4 was not my resident, but I was keeping R4 with me when I was going from room to room. I was pulling her in the Geri-chair from room to room to keep an eye on her. I thought I was helping. R4's C.N.A. was somewhere else. I am the person that tied the sheet over R4. I didn't know how to keep her safe because she was walking around from room to room and pulling on residents while they were sleeping. R4 was sleeping and she kept walking into other resident's rooms. Other residents were getting upset. I placed R4 into the Geri-chair around 3:30AM, and I tied the sheet around R4's waist. R4 was able to use her arms and her legs, but she could not get out of the Geri-chair, because R4 was leaned all the way back like a couch. R4 was wide awake, she was clapping. I thought I was helping R4. After I placed R4 into the Geri-chair and tied her, R4 was leaned back and she was clapping. She did not attempt to get up. Nobody knew the sheet was tied over R4 in the chair. Around 5:30AM, the C.N.A from the day shift saw R4 was tied in the Geri-chair. C.N.A reported it to the nurse. I did not find out I was reported until I was at home around 9:00AM. Everybody from the day shift called me trying to find out who tied the sheet. V1 (administrator) told me I could not come back. I got fired because they told me not to come back. The morning C.N.A took a picture of the resident tied in the chair. At 5:30AM, I dropped R4 off to the assigned C.N.A. She asked me how I kept her in the chair. I walked off because I had to start my rounds before I left. I did not say anything. I don't know the C.N.A, and I did not even think about the question. I was upset that the assigned C.N.A was not with R4. She was supposed to be with R4, and she was not. I had to keep R4 company so she's safe. After a certain time, I placed R4 into the Geri-chair, and I tied the sheet over R4, so she did not fall out. I did not see anybody removing R4 from the chair because I had to start my work. On 03/27/2026 at 1:40PM, V2 (director of nursing) stated, We do not have a restorative director at this time. R4 is ambulatory. R4 does not use any assistive devices with walking. R4 does not utilize a Geri-chair. R4 is able to transfer herself. R4 does not require staff assistance with transfers. Placing R4 into a Geri-chair and tying a sheet over R4 would be considered a restraint.On 03/27/2026 at 2:12PM, V16 (attending physician) stated, I think this patient had some developmental delays. Apparently, someone took it upon themselves to place the resident in the Geri-chair. The more alarming thing was they used a sheet to tie the resident down. This is wrong. This is never okay. is considered a restraint. was the aide's misguided action. I was made aware R4 was a wonderer, and an aide took some bed sheets and tied the resident down. We want to protect the residents with developmental delays. We talked about this issue. We had a special meeting with the administrator and everybody about this. I know sometimes R4 sits in the Geri-chair in the mornings I think it was the aide's own independent action. It was inappropriate. On 03/28/2026 at 8:33AM, V17 (social services director) stated, R4 ambulates. R4's cognitive status is moderately impaired. R4's BIMS (Interview for Mental Status) score is 9. R4 ambulates independently. R4 does not require a wheelchair or a Geri-chair. I am aware of the incident that occurred on 03/10/2026. I know allegedly the resident was sitting in a Geri-chair and a chemical restraint or restraint was used. R4 had something wrapped around her legs or her thighs. It technically is a restraint. When I talked with R4, she was fine. R4 said she feels safe in the facility. R4 was not in any kind of distress. I have been checking on R4 every day. I continued to check on R4 closely for 72 hours. Staff have been assisting with the 1 to 1 care for R4 to make sure R4 is safe. It is never okay to use a sheet to tie over a resident.On 03/28/2026 at 9:00AM, V6 (certified nursing assistant) stated, On 03/10/2026, I came in the morning after 7:00 AM. I saw R4 sitting in the chair in the dining room. When I looked closely, I saw a sheet tied over R1's chair. Usually, R4 would get up out of the chair. It is R4's normal routine to sit in the chair, but she could not get out of the chair. I asked R4 why she can't get up. When I looked closer, I saw the sheet was restraining R4 from getting out of the chair. I went to look for the nurse and tried to report it. I don't remember if I un-tied her or someone else untied R4. I could (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	have untied R4, but I just don't remember because there was a lot going on that morning. The next thing I know, R4 was walking. I reported this to the nurse. I did not inform the administrator directly. I was called downstairs by the administrator, the director of nursing and the department manager. I received abuse prevention training in this facility. The use of restraints is prohibited. It is considered abuse. There are different levels of restraints. When I went downstairs to speak to the administrator, the director of nursing and the manager, I was suspended. I was suspended because I did not go to the administrator right away, and I did not go to the chain of command when reporting abuse.On 03/28/2026 at 9:15AM, surveyor attempted to reach V11 (certified nursing assistant) via telephone, for an interview. V11 answered surveyor's call and said she would call the surveyor back. Surveyor did not receive a call back from V11. On 03/28/2026 at 9:26AM, V8 (licensed practical nurse/house supervisor) stated, On 03/10/2026, I did not work on the 3rd floor. I always work on the second floor. When I was going home at 8:00AM, V6 (certified nursing assistant) told me she found R4 in the Geri-chair and R4 was wet. I was on my way out the door. I told V6 to go and tell the nurse. I was not the nurse; I don't work on floor. I asked V6 what time she came in, and she told me she came in at 7:00AM. I did not hear R4 was tied to the chair with a sheet. V6 informed me on the phone. It was loud and maybe I did not hear it correctly. I did not hear part about the sheet being tied over R4. I told V6 to tell the nurse because I was not the nurse on duty anymore. I was leaving. I asked her why are you telling me now? I am not the nurse. If I would have heard the part R4 was tied to the Geri-chair, I would rush to assess R4 and I would let the administrator know immediately that is a restraint. I would call immediately to report it to the administrator. I would not wait. I would never delay reporting this. I would have immediately called the abuse coordinator, which is the administrator. When I got home around 9:00 AM, the assistant administrator called me. She called me and asked me if V6 told me R4 was tied to the chair. I told her I did not hear part. I told the assistant director of nursing (ADON) I only heard the part R4 was sitting in a chair, and she was wet. This is why I told V6 to inform the nurse. They told me they want to investigate it. According to V6, there were 2 nurses on the 3rd floor that day when the incident occurred. I was not working on the 3rd floor. I was not the supervisor day. When I am supervising, I need to make rounds on every floor. But that day, I was working on the 2nd floor. I did receive abuse prevention training. Restraints are not allowed. I would have called immediately if I heard the part that R4 was restrained because it is not allowed. R4 ambulates independently and she does not utilize a Geri-chair. I was terminated. I don't know why they terminated me. I think it's because I did not notify the administrator.On 03/28/2026 at 9:37AM, V10 (certified nursing assistant) stated, I remember the C.N.A coming in and I was on orientation. The C.N.A did not introduce herself and I don't remember her name. I came to work and I was on orientation. I saw the C.N.A roll R4 into the dining room, and I gave R4 a cup of water. I did not see a sheet being tied over R4. I did not see R4 being tied with a sheet. I was not paying attention. That would be considered a restraint. I got fired and it was my third day of orientation. V2 (director of nursing) said in the dining room I had dosed off. I was on the phone with the director of nursing. The C.N.A left me sitting in the dining room for maybe 2 or 3 hours. First, she was in there with me. It was too warm. She left me sitting in there. After a while you get tired if you're just sitting there. She did not show me anything. I was not fired for the restraint use because I did not see the resident restrained.On 03/28/2026 at 9:41AM, surveyor attempted to call V7 (wound care nurse) via telephone, for an interview. Surveyor left a voicemail. Surveyor did not receive a call back; therefore, surveyor was not able to obtain an interview. On 03/28/2026 at 9:45AM, V9 (licensed practical nurse) stated, I saw the resident in the Geri-chair and her hands were visible, she (R4) was not in distress. Both hands were visible. She was alert and oriented when I saw her. I did not see the sheet tied around R4's waist. I did not know R4 was tied, and I did not see any of that. I was not aware of R4 being restrained. I was notified about this incident when I got home. I did my rounds. The last time I saw her was 7:15AM, when I did my last rounds. R4 was in the day room. I left the building at 7:45AM. When I got home, they called me around 9:00 AM, but I am not sure exactly what time it was. V2 (director of (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	nursing) called me. She was telling me about the incident, and I told her I did not know anything about it. Then, V2 called back when they were in the morning meeting, and I informed them I did not know anything about it. I think they suspended me the second time they called me. After 7 days, human resources and the administrator called me. They told me I cannot come back to the building because I am terminated. This is the only incident I had while working in this building. I received abuse prevention training. I received education pertaining to restraints.R4's Progress Note (dated 03/10/2026) documents, Writer was informed by administration staff alleged inappropriate care was displayed. Resident was immediately assessed with no skin injuries or pain. Resident expressed no mental/ emotional distress. Emergency contact updated with request for no police notification. Facility protocol implemented. Physician made aware. Well-being checks conducted by social services.R4's Progress Note (dated 03/10/2026) documents, Late Entry: Note Text: 72 Hours Follow-Up 1/3 writer was informed the resident claimed/alleged staff exhibited inappropriate care. Resident appears to be in a stable mood and does not show any signs of distress. Writer inquired whether the resident feels safe in her surroundings. The resident replied, Yes. Writer encouraged resident to establish appropriate boundaries with staff. Writer also urged the resident to seek assistance from staff when necessary. Furthermore, writer motivated the resident to engage in activities. Writer advised resident to utilize the call light as required. Writer encouraged the resident to communicate any advocacy needs, as we are here to provide assistance as necessary. Resident expressed her understanding. Writer will continue to follow up as needed.R4's Skin/Shower Worksheet (dated 03/13/2026) documents skin discoloration/bruising to R4's upper and lower extremity. Guidelines for Physical Restraints/Seclusion (dated 05/17/2023) states in part: It is the policy of the facility to use physical restraints only as a last resort and only after every other alternative to a physical restraint (based on assessment) seemed to have the potential for being used successfully, has been tried, and has failed. The use of a physical restraint and/or device is to enable and promote functioning at the highest practicable physical, mental, or psychosocial well-being. It will be used only after the resident has been assessed and it has been determined by the IDT the restraint to be used is the least restrictive and for the least amount of time. Abuse Prevention Program (revised 03/01/2021) states in part: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. Employees are required to immediately report any incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment, or a crime against a resident they observe, hear about, or suspect to the administrator if available or an immediate supervisor who must immediately report it to the administrator.